SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
Company Tracking Number:	*HP12GPAR, ET AL.*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

Filing at a Glance

Company: ReliaStar Life Insurance Company

Product Name: Group Long Term Disability Income	SERFF Tr Num: MNNP-127625059	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved	State Tr Num: 49784
Sub-TOI: H11G.003 Long Term	Co Tr Num: HP12GPAR, ET AL.	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Donna Lambert
	Author: Kathy Healy	Disposition Date: 10/04/2011
	Date Submitted: 09/14/2011	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 11/04/2011

State Filing Description:

General Information

Project Name: Assoc LTD	Status of Filing in Domicile: Pending
Project Number: HP12GPAR, et al.	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Association	Overall Rate Impact:
Filing Status Changed: 10/04/2011	
State Status Changed: 10/04/2011	Deemer Date:
Created By: Kathy Healy	Submitted By: Kathy Healy

Corresponding Filing Tracking Number:

Filing Description:

Group Long Term Disability Income Policy/Certificate Forms HP12GPAR, et al.

We are submitting a new Group Long Term Disability Income Insurance Policy, Certificate, Riders and Applications for filing with your Department. These forms are new and have not been previously filed with your Department.

This group long term disability income product will be marketed to eligible associations in your state through direct response solicitation. Members and their spouses may be eligible for coverage. The forms are designed to offer multiple options to the group policyholder. The Riders are additional benefit options available to insureds.

SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
Company Tracking Number:	*HP12GPAR, ET AL.*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

The policy and certificate are each filed under one form number. Provisions contained in the policy and certificate forms have been numbered individually with italicized internal numbers, located at the end of each provision on the right side, for ease in providing variable information. These numbers will not appear in the policy or certificate when printed for policyholders/insureds.

The enclosed applications may be in written or electronic format. When presented electronically, the actual wording of the statements and questions will not change, but based on responses, they may appear in a slightly different order.

The brackets denote variable material. An explanation of the variable material is contained in the attached variable chart.

Company and Contact

Filing Contact Information

Kathy Healy, Compliance Analyst	kathy.healy@us.ing.com
P.O. Box 20	612-372-5795 [Phone]
Route 7782	612-342-3695 [FAX]
Minneapolis, MN 55440-0020	

Filing Company Information

ReliaStar Life Insurance Company	CoCode: 67105	State of Domicile: Minnesota
P.O. Box 20	Group Code: 229	Company Type:
Minneapolis, MN 55440-0020	Group Name:	State ID Number:
(612) 372-5246 ext. [Phone]	FEIN Number: 41-0451140	

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,100.00
Retaliatory?	No
Fee Explanation:	AR is $50 per form. Our domicile state filing fee is $150 per fiilng.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	$1,100.00	09/14/2011	51577440

SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
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TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/04/2011	10/04/2011

SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
Company Tracking Number:	*HP12GPAR, ET AL.*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

Disposition

Disposition Date: 10/04/2011
Implementation Date: 11/04/2011
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
Company Tracking Number:	*HP12GPAR, ET AL.*		
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Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Variable Chart	Accepted for Informational Purposes	No
Form	Policy	Approved	No
Form	Certificate	Approved	No
Form	Schedule of Benefits	Approved	No
Form	AD&D Rider	Approved	No
Form	Assisted Living Rider-Stated	Approved	No
Form	Assisted Living Rider-Percentage	Approved	No
Form	COLA Rider	Approved	No
Form	GPO Rider	Approved	No
Form	Hospital Income Rider	Approved	No
Form	Recovery Rider	Approved	No
Form	BOE Rider	Approved	No
Form	Spouse/DP Rider	Approved	No
Form	Transition Rider	Approved	No
Form	Specified Condition Rider	Approved	No
Form	Modifications Rider	Approved	No
Form	UW App	Approved	No
Form	SI App	Approved	No
Form	BOE App	Approved	No
Form	BOE Supp App	Approved	No
Form	UW Spouse/DP App	Approved	No
Form	SI Spouse/DP App	Approved	No
Form	Accident App	Approved	No

SERFF Tracking Number:	*MNNP-127625059*	*State:*	*Arkansas*
Filing Company:	*ReliaStar Life Insurance Company*	*State Tracking Number:*	*49784*
Company Tracking Number:	*HP12GPAR, ET AL.*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*Group Long Term Disability Income*		
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*		

Form Schedule

Lead Form Number: HP12GPAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/04/2011	HP12GPAR	Policy/Contract/Fraternal Certificate	Policy	Initial			HP12GPAR.pdf
Approved 10/04/2011	HC12GPAR	Certificate	Certificate	Initial			HC12GPAR.pdf
Approved 10/04/2011	HS12GP	Schedule Pages	Schedule of Benefits	Initial			HS12GP.pdf
Approved 10/04/2011	R-08681	Certificate Amendment, Insert Page, Endorsement or Rider	AD&D Rider	Initial			R-08681.pdf
Approved 10/04/2011	R-08682	Certificate Amendment, Insert Page, Endorsement or Rider	Assisted Living Rider-Stated	Initial			R-08682.pdf
Approved 10/04/2011	R-08683	Certificate Amendment, Insert Page, Endorsement or Rider	Assisted Living Rider-Percentage	Initial			R-08683.pdf
Approved 10/04/2011	R-08684	Certificate Amendment, Insert Page, Endorseme	COLA Rider	Initial			R-08684.pdf

		nt or Rider				
Approved 10/04/2011	R-08685	Certificate Amendment, Insert Page, Endorsement or Rider	GPO Rider	Initial		R-08685.pdf
Approved 10/04/2011	R-08686	Certificate Amendment, Insert Page, Endorsement or Rider	Hospital Income Rider	Initial		R-08686.pdf
Approved 10/04/2011	R-08687	Certificate Amendment, Insert Page, Endorsement or Rider	Recovery Rider	Initial		R-08687.pdf
Approved 10/04/2011	R-08688	Certificate Amendment, Insert Page, Endorsement or Rider	BOE Rider	Initial		R-08688.pdf
Approved 10/04/2011	R-08698	Certificate Amendment, Insert Page, Endorsement or Rider	Spouse/DP Rider	Initial		R-08698.pdf
Approved 10/04/2011	R-08680	Certificate Amendment, Insert Page, Endorsement or Rider	Transition Rider	Initial		R-08680.pdf
Approved	R-08689	Certificate	Specified Condition	Initial		R-08689.pdf

SERFF Tracking Number:	*MNNP-127625059*		*State:*	*Arkansas*		
Filing Company:	*ReliaStar Life Insurance Company*		*State Tracking Number:*	*49784*		
Company Tracking Number:	*HP12GPAR, ET AL.*					
TOI:	*H11G Group Health - Disability Income*		*Sub-TOI:*	*H11G.003 Long Term*		
Product Name:	*Group Long Term Disability Income*					
Project Name/Number:	*Assoc LTD /HP12GPAR, et al.*					
10/04/2011		Amendment, Insert Page, Endorsement or Rider	Rider			
Approved 10/04/2011	R-08690	Certificate Amendment, Insert Page, Endorsement or Rider	Modifications Rider	Initial		R-08690.pdf
Approved 10/04/2011	DIUW11-ST	Application/ Enrollment Form	UW App	Initial		DIUW11-ST.pdf
Approved 10/04/2011	DISI11-ST	Application/ Enrollment Form	SI App	Initial		DISI11-ST.pdf
Approved 10/04/2011	DIBOE11-ST	Application/ Enrollment Form	BOE App	Initial		DIBOE11-ST.pdf
Approved 10/04/2011	DIBOESUPP11-ST	Application/ Enrollment Form	BOE Supp App	Initial		DIBOESUPP11-ST.pdf
Approved 10/04/2011	DIUWSPDP11-ST	Application/ Enrollment Form	UW Spouse/DP App	Initial		DIUWSPDP11-ST.pdf
Approved 10/04/2011	DISISPDP11-ST	Application/ Enrollment Form	SI Spouse/DP App	Initial		DISISPDP11-ST.pdf
Approved 10/04/2011	DIACCIDENT11-ST	Application/ Enrollment Form	Accident App	Initial		DIACCIDENT11-ST.pdf

RELIASTAR LIFE INSURANCE COMPANY
Home Office, Minneapolis, Minnesota 55440

GROUP POLICY NUMBER: [GH-12345-6]

POLICYHOLDER: [ABC Association]

EFFECTIVE DATE: [August 1, 2011]

ANNIVERSARY DATE: [August 1]

ReliaStar Life Insurance Company (ReliaStar Life) will pay benefits according to the terms and conditions of this Group Policy when ReliaStar Life receives proof of a valid claim.

The Group Policy is issued in consideration of the Policyholder's application and payment of premiums when due. A copy of the Policyholder's application is attached and forms a part of this Group Policy. Insurance is issued to any individual under the terms of this Policy in consideration of the insured's application, including any amendments which the insured may accept by signature, and payment of premiums when due.

[OPTIONALLY RENEWABLE - ReliaStar Life may decline to renew this Group Policy on any Anniversary Date.]
HP9189GP

This Group Policy is effective on the Effective Date. The first Policy Year ends on the Anniversary Date. Policy Years are determined from the Policy Anniversary. Benefit periods begin and end at 12:01 a.m. standard time at the Policyholder's address shown on the application.

READ THIS GROUP POLICY CAREFULLY! This is a legal contract. The contract includes –
- Part A. General Provisions,
- Part B. The Insureds' Benefits Section and the provisions of the Certificate which are made a part of that section,
- the Policyholder's Application,
- the insureds' individual application and signed amendments, and
- any riders attached to the insureds' Certificate amending coverage under this Policy.

This Group Policy is delivered in the state of Ohio and is governed by its laws.

Executed at Minneapolis, Minnesota on [DATE].

President

Registrar

Secretary

This Group Policy Provides
Total Disability Income Insurance

HP9190GP

Contributory

Nonparticipating

HP9191GP

[THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.]
HP9266GP

PART A. GENERAL PROVISIONS

Premium Schedule

Premium Due Date: [First day of the month]

Minimum Number of Insureds: [XX]

INITIAL PREMIUM RATES guaranteed until [DATE].

[Case Rate Tables and Factors]
RP974GP

PREMIUM
The premium is the amount ReliaStar Life charges for insurance. The initial premium rates are shown on the Premium Schedule.

The first premium is due on the Effective Date. Each later premium is due on the Premium Due Date.

The Policyholder or designated administrator sends the premiums to ReliaStar Life's Home Office. ReliaStar Life applies premiums consecutively to keep the insurance in force.

ReliaStar Life may change the premium rates –
• any time that the Group Policy terms are amended.
• on any Premium Due Date unless specified in the Premium Schedule.

ReliaStar Life will give the Policyholder at least [60] days prior written notice of a change in premium rates.

If ReliaStar Life receives any premium that was not due, ReliaStar Life will refund it. ReliaStar Life will not refund a premium not due if it was used in calculating a retroactive rate credit which was paid.

Premiums are not due for a period of time during which an insured's coverage was not in force, or premiums waived under the Waiver of Premium Benefit.
HP9192GP

GRACE PERIOD
If a premium is not paid by its due date, ReliaStar Life allows 31 days from the due date in which to pay it. ReliaStar Life calls this the Grace Period. Full payment must be received by the 31st day. If ReliaStar Life receives payment during the Grace Period the Group Policy stays in force.

If the Policyholder sends ReliaStar Life notice of termination during the Grace Period, the Policyholder must pay premiums for any period the Group Policy was in force during the Grace Period.
HP9204GP

PROOF OF INSURABILITY
ReliaStar Life reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to ReliaStar Life as a condition to the issuance of the insurance coverage.

The amount the person applies for can be no more than that for which they are eligible under the Group Policy.
HP9193GP

NONPARTICIPATING POLICY
This policy is nonparticipating and neither the Policyholder nor any insured will be entitled to share in ReliaStar Life's surplus earnings.
HP9194GP

[EXPERIENCE RATING PLAN
After each policy year this policy, for purposes of determination of a retroactive rate credit, if any, will be subject to experience rating with respect to the prior policy year. ReliaStar Life's experience rating plan in effect at the time of the experience rating will be used. The experience rating plan will take into account those reserves and expenses which ReliaStar Life determines to be necessary and advisable. If a retroactive rate credit results, it will be paid in cash or otherwise made accessible to the Policyholder in accordance with the experience rating agreement entered into by ReliaStar Life and the Policyholder.]
HP9195GP

CHANGING THE POLICY
This Group Policy may be changed at any time by written agreement between ReliaStar Life and the Policyholder. No change in this Group Policy is valid unless it is approved and signed by one of ReliaStar Life's designated corporate officers or an Assistant Secretary. Agents or brokers do not have the right to change this Group Policy, waive any of its provisions, or bind ReliaStar Life in any way.
P95GP

RENEWAL REQUIREMENTS
To keep this Group Policy in force from Policy Year to Policy Year –
– all premiums must be paid to ReliaStar Life when due, and
– ReliaStar Life must not have exercised its option to terminate this Policy.

This Group Policy will be kept in force if all Renewal Requirements are met unless ReliaStar Life gives the Policyholder [60] day notice of its intent not to renew the Group Policy.
HP9196GP

TERMINATION
If ReliaStar Life receives, while all premiums are paid, written notice from the Policyholder to terminate this Group Policy, then the Group Policy terminates on the Premium Due Date after ReliaStar Life receives written notice.

If ReliaStar Life receives, during a grace period, written notice from the Policyholder to terminate this Group Policy, then the Group Policy terminates on the date ReliaStar Life receives written notice.

If a premium is not paid by the end of the grace period, then the Group Policy terminates at the end of the grace period.

If the renewal requirements of this Group Policy are not met, then the Group Policy terminates at the end of the Policy Year.

[If ReliaStar Life provides written notice to the Policyholder terminating this Group Policy, then the Group Policy terminates on the first Premium Due Date following a [60] day period from termination notification.]

Termination of this Group Policy will be without prejudice to any claims that originated prior to the date of termination.
HP9197GP

REINSTATEMENT
ReliaStar Life will not reinstate this Group Policy after it has terminated. To become insured after insurance has stopped, the Policyholder must submit a new application.
P98GP

REPRESENTATIONS NOT WARRANTIES
Unless fraudulent, all statements made by or on behalf of anyone insured under this Group Policy are representations and not warranties. No statement can be used to void coverage under this Group Policy or be used in ReliaStar Life's defense if ReliaStar Life refuses to pay a claim, unless a copy of the statement is furnished to the insured or the insured's beneficiary.
P988GP

INCONTESTABILITY
The coverage under this Group Policy has a 2 year contestable period starting from the Effective Date of the Group Policy. During those 2 years, ReliaStar Life can contest the validity of this Group Policy because of inaccurate or false information received on the Policyholder's application. ReliaStar Life can require the Policyholder to provide information that could lead to ReliaStar Life's contesting the Policy or refusing to pay benefits.

An insured's coverage under this Group Policy also has a 2 year contestable period, as defined in the Certificate, starting from the effective date of the insured's coverage.
HP9198GP

MAINTAINING RECORDS
The Policyholder or designated administrator will maintain adequate records of any information ReliaStar Life requires to administer this Group Policy. ReliaStar Life owns the records relating to the insurance provided by this Group Policy and can obtain them from the Policyholder at any time.
P989GP

MISSTATEMENT OF AGE
If the insured's age is misstated, ReliaStar Life will adjust either the premium or the amount of insurance according to the correct age.
HP9199GP

CLERICAL ERROR
If a clerical error is made in keeping records on the insurance under this Group Policy, it will not affect insurance that is otherwise valid.

A clerical error does not continue insurance that has otherwise stopped. If an error causes a change in premium payment, ReliaStar Life will make a fair adjustment. This clerical error provision applies whether ReliaStar Life or the Policyholder makes the error.
HP9200GP

CERTIFICATES
Through the Policyholder or its Administrator, ReliaStar Life issues a certificate for delivery to each insured. The certificate is evidence of insurance and is based on the statements made by the insured in the application for coverage. It describes the insured's benefits and other provisions affecting the insured's coverage.
HP9201GP

ELIGIBLE NEW MEMBERS
Eligible new Members, and eligible new Spouses if included under the Group Policy, may be periodically added to the group originally insured according to the terms and provisions of the Group Policy.
HP9487GP

PART B. INSUREDS' BENEFITS SECTION

The provisions listed below, contained in the Certificate(s) issued under this Group Policy for Members specified in the Certificate Index, are made a part of this Group Policy.

Schedule of Benefits
Total Disability Income Insurance
[Residual Disability]
Claim Procedures
Premiums
General Provisions
Definitions

The Certificates are identified by a B-number. Riders and Stickers, if any, amending the provisions of the Certificate are also made a part of this Group Policy. The provisions are made a part of the Group Policy from the Effective Date listed below. The Class of Members to whom provisions apply are also listed in the Certificate Index.

Wherever a reference to “You” or “Your” is made in a Certificate provision, rider or sticker, it means a Member insured under this Group Policy.

CERTIFICATE INDEX

Class of Insureds	**Certificate Number**	**Effective Date**
[ ]	[ ]	[ ]

HP9202GP

RIDER/STICKER INDEX

[Accidental Death and Dismemberment Rider]
[Assisted Living Benefit Rider - Stated Benefit]
[Assisted Living Benefit Rider - Percentage Benefit]
[Business Overhead Expense Benefit Rider]
[Cost of Living Adjustment Rider]
[Guaranteed Purchase Option Rider]
[Hospital Indemnity Benefit Rider]
[Recovery Benefit for Total Disability Rider]
[Spouse[/Domestic Partner] Benefit Rider]

Class of Insureds	**Certificate Number**	**Rider/Sticker Number**	**Effective Date**
[ ]	[ ]	[ ]	[ ]

HP9203GP

CONTENTS

[B-1234 (08-11 DRAFT)]

C07TC

[THIS CERTIFICATE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.]
H069TC

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the Group Policy listed below to the Policyholder. All benefits are controlled by the terms and conditions of the Group Policy.

The Group Policy is on file in the Policyholder's office. You may look at the Group Policy there.
C01CT

Group Policy Number	Policyholder
[123456-7]	[ABC Association]

C03CT

The insurance included in this certificate applies to You only if You have elected and are insured for it. This certificate is issued based on the statements You made in Your application for insurance, a copy of which is attached and made part of this certificate.
H023CT

The certificate summarizes and explains the parts of the Group Policy that apply to You. This certificate is not an insurance policy. In any case of differences or errors, the Group Policy will govern.

This certificate replaces any other certificates ReliaStar Life may have given You under the Group Policy.
H024CT

You have 30 days to examine this certificate. If You are not satisfied, You may return it to ReliaStar Life within 30 days of the Effective Date of Your coverage. We will consider it void from the Effective Date of Your coverage and any premiums paid will be returned.
H025CT

DISABILITY INCOME INSURANCE

H90DS

Eligibility
You are eligible for coverage on the Group Policy Effective Date if -
- You are at least age 18 and under age [60] on the date of application.
- You are an active Member of [ABC Association].
- You are Actively at Work.

If You are an active Member of [ABC Association] and are not Actively at Work or are Disabled on the Group Policy Effective Date, You are eligible for coverage after You have been Actively at Work for [6] consecutive months.

If You are not an active Member of [ABC Association] on the Group Policy Effective Date, You are eligible for coverage under the Group Policy on the first day of the month following the date You become an active Member of [ABC Association] and are Actively at Work.
H320DS

Effective Date
Your insurance under the Group Policy is effective on the Effective Date shown in the Schedule of Benefits, subject to providing any satisfactory proof of medical insurability and payment of any premium due.
H326DS

Termination of Insurance
Your insurance under this certificate will terminate on the earlier of:
- The date You are no longer Actively at Work.
- The date You attain age [65-70].
- The date You become a member of the armed forces of any country or international authority. In such event, the pro rata unearned premium will be returned to You for any period of full-time active duty for more than two months provided You notify ReliaStar Life within 12 months of entering the armed forces.
- The premium due date when the required premium is not paid except as provided in the Individual Grace Period provision in this Certificate.
- The date ReliaStar Life receives written notice to terminate Your insurance or the date stated in the notice if later.
- The date the Group Policy is terminated.

Termination of Your insurance will be without prejudice to any claims that originated prior to the date of termination.
H321DS

Foreign Residency Limitation
ReliaStar Life will limit Disability Benefits to 12 months for each Period of Disability if You have resided outside the United States, its territories and jurisdictions, or Canada for more than 12 consecutive months for purposes other than employment in Your Own Occupation.
H327DS

Proof of Insurability
ReliaStar Life may require proof of medical and financial insurability for benefit increases under the Group Policy. Proof of medical insurability includes proof of good health.
H322DS

DISABILITY INCOME INSURANCE

Qualifying for Benefits
ReliaStar Life pays benefits if You become Disabled and qualify to receive benefits. The benefit payable is based on the Schedule of Benefits in effect on the date You become Disabled.

To qualify for benefits, all of the following conditions must be met:
You must -
- be insured on the date You become Disabled and the condition causing Your Disability is not excluded from coverage.
- be insured on the date the Benefit Elimination Period begins.
- send written notice of the Disability as described in the Claim Procedures section.
- provide required proof of Disability due to [Sickness or] Injury.

H323DS

Benefit Elimination Period
[The Benefit Elimination Period is the length of time You must be continuously Totally Disabled before You qualify to receive any benefits.]
[The Benefit Elimination Period is the length of time You must be continuously Totally Disabled or Residually Disabled before You qualify to receive any benefits.]
[The Benefit Elimination Period is the length of time You must be continuously Totally Disabled or Residually Disabled or Catastrophically Disabled before You qualify to receive any benefits.]

The Benefit Elimination Period begins on the first date You see a Doctor because of [Sickness or] Injury causing Your reported Disability.

The Benefit Elimination Period is shown on the Schedule of Benefits.
H598DS

[Retroactive Benefits
After You have been continuously Totally Disabled, while covered under this Certificate and the Total Disability Benefit, for a period of time that would satisfy the Benefit Elimination Period, the Total Disability Benefits will then be payable retroactive to the first day of the Benefit Elimination Period.]
H5243DS

[Retroactive Benefits for Hospital Confinement
If You are Hospital confined for 3 consecutive days due to an Accidental Injury that occurs while Your insurance under the Group Policy is in force, ReliaStar Life will waive the Benefit Elimination Period. The Total Disability Benefits will then be payable retroactive to the first day of the Benefit Elimination Period.]
H5244DS

Monthly Income Benefit
[The Monthly Income Benefit for Total Disability is the lesser of:
- [40-80]% of Your Monthly Earned Income rounded up to the nearest $100 increment, and
- the Maximum Monthly Income Benefit shown on the Schedule of Benefits.

If [40-80]% of Your Monthly Earned Income is less than the Maximum Monthly Benefit shown on the Schedule of Benefits, ReliaStar Life will refund premium paid by You during the 2 years preceding the date of Disability for the amount of the Maximum Monthly Benefit in excess of [40-80]% of Your Monthly Earned Income.]

[The Monthly Income Benefit for Total Disability is the Maximum Monthly Income Benefit shown on the Schedule of Benefits.]
H599DS

Monthly Income Benefit Payable
The Monthly Income Benefit Payable is Your Monthly Income Benefit reduced as stated in the [Reduction in Coverage for Other Income] [Relation of Earnings to Insurance] provisions of this Certificate.
H714DS

DISABILITY INCOME INSURANCE

Benefit Payments
Monthly Income Benefits Payable are paid at the end of each month for the period for which You qualified. If You are Disabled for part of a month, the benefit payable is based on 1/30th of Your Monthly Income Benefit Payable for each day You are disabled. Benefits continue while You are Disabled up to the Maximum Benefit Period shown on the Schedule of Benefits.
H715DS

[Reduction in Coverage for Other Income
Benefits payable as the result of Your Total Disability will be the lesser of:
- the Maximum Monthly Benefit Amount.
- [40-80]% of Your Monthly Earned Income minus any Other Income, including those for which You could collect but did not apply.

The following are sources of Other Income:
[• All income from any employer or for any work.]
[• Any benefits and awards You receive or are eligible to receive under:
  – Workers' Compensation Law.
  – Occupational Disease Law.
  – Any other similar Act or Law.]
[• Any disability income benefits You receive or are eligible to receive under:
  – any compulsory benefit Act or Law.
  – any other group insurance policy with an employer or with an association.
  – any governmental disability income benefits You receive or are eligible to receive under a retirement system as the result of a job with any employer.]
[• Any benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, the Jones Act, and any other similar plan or Act. Benefits include:
  – disability benefits you are eligible to receive and any disability benefits Your spouse or Your children receive or are eligible to receive as a result of Your disability.
  – retirement benefits You receive and any retirement benefits Your spouse or Your children receive as a result of Your receipt of retirement benefits.]
[• Any benefits You receive from any employer's sick leave or salary continuation plan.]
[• Any benefits from an employer's retirement plan, the Public Employees Retirement System and the State Teachers Retirement System that you:
  – receive as disability benefits.
  – voluntarily choose to receive as retirement benefits.
  – receive as retirement benefits once You reach the greater of age 62 or normal retirement age, as defined in an employer's retirement plan.

  Regardless of how the retirement funds from any employer's plan are distributed, for the purposes of determining ReliaStar Life's benefit to You, ReliaStar Life considers Your and any employer contributions to be distributed at the same time throughout Your lifetime.

  Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

  Retirement benefits under a retirement plan are benefits that are paid based on an employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

  Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition.]
[• Any benefits for loss of time or lost wages You receive from the mandatory portion of a no-fault motor vehicle insurance plan or automobile liability insurance policy.]
[• Any amount You receive under any Unemployment Compensation law.]
[• Any amounts You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.]

Other Income must be payable as a result of the same Disability for which You are receiving a benefit from ReliaStar Life, except for retirement benefits.

[ReliaStar Life will NOT subtract from Your Gross Disability Benefit any amounts You receive from the following sources:
• 401(k) plans.
• profit sharing plans.
• thrift plans.
• tax sheltered annuities.
• stock ownership plans.
• non-qualified plans of deferred compensation.
• pension plans for partners.
• military pension and military disability income plans.
• credit disability insurance.
• franchise disability income plans.
• a retirement plan from another employer.
• individual retirement accounts (IRA)
• individual disability income plans.]

[ReliaStar Life will not reduce benefits You receive from ReliaStar Life under the Retirement Contribution Benefit or for amounts that You roll over or transfer to an eligible retirement plan.]

As used in this Reduction provision, **Pension Plan** is a plan that provides retirement benefits and which is not wholly funded by Your contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.]
H5231OI

[Minimum Monthly Income Benefit
If You receive Other Income, it will be subtracted from the benefit You would otherwise receive. However, after You qualify for Monthly Income Benefits, ReliaStar Life will pay You at least the Minimum Monthly Income Benefit of $100.]
H716DS

[Lump Sum Payments
If You are paid Other Income benefits in a lump sum that represents benefits otherwise payable monthly in the future, ReliaStar Life will prorate the lump sum over the period of time it would have been paid if not paid in a lump sum. If such period cannot be determined, ReliaStar Life will prorate the lump sum over a period equal to the Maximum Benefit Period shown in the Schedule of Benefits.]
H717DS

[Cost of Living Increases
After the first deduction for each of the Other Income sources, ReliaStar Life will not further reduce the amount of Your Monthly Benefit under the Group Policy due to cost of living increases You receive from any of the sources described in the Reduction in Coverage for Other Income provision.]
H5245DS

[Estimating Amounts of Other Income
ReliaStar Life has the right to estimate the amount of benefits You may be eligible to receive as Other Income. ReliaStar Life can reduce its benefits to You by the estimated amount if:
• You have not been awarded but have not been denied such benefits.
• You have been denied such benefits and the denial is being appealed.
• You are applying for such benefits.

ReliaStar Life will NOT reduce its payments to You by the estimated amount if:
• You apply or reapply for the benefits and appeal Your denial through all of the administrative levels ReliaStar Life believes are necessary.
• You sign ReliaStar Life's reimbursement agreement form stating that You promise to pay ReliaStar Life any overpayment caused by an award.

If ReliaStar Life reduces its benefits to You by an estimated amount -
• ReliaStar Life will adjust its benefit to You when you provide proof of the amount awarded.
• ReliaStar Life will issue a lump sum refund of the estimated amount if You were denied benefits and have completed all appeals (or reapplications) ReliaStar Life believes are necessary.]
H5246DS

DISABILITY INCOME INSURANCE

[Relation of Earnings to Insurance
At time of claim, the Monthly Income Benefit You would otherwise receive will be reduced if the sum of all benefits provided for this same Period of Disability under all Valid Loss of Time Coverage, including the Group Policy, exceeds the greater of:
- Your Monthly Earned Income at the time Your Disability begins.
- The average of Your Monthly Earned Income for the 2 years just prior to the start of Your Disability.

The reduced benefit will be proportional to the amount that Your Monthly Earned Income or the average of Your Monthly Earned Income bears to the total amount of Your benefits under the Valid Loss of Time Coverage for the same Period of Disability.]
H5101DS

[Minimum Monthly Income Benefit
This provision will not operate to reduce the total amount of Your benefits under all Valid Loss of Time Coverage below the lesser of $100 and the sum of all monthly benefits specified under all Valid Loss of Time Coverage.

ReliaStar Life will refund a portion of the premiums paid during the 2 years just prior to the start of Your Disability, in the same proportion as any reduction in benefits.]
H5264DS

[Valid Loss of Time Coverage
Coverage provided by:
- All loss of time or disability income benefits provided by individual or group policies.
- All employer and association sponsored disability income benefits and salary continuation plans.
- All governmental disability income benefits including state disability income benefits.
- Workers' Compensation.]

H5265DS

Overpayment
If ReliaStar Life pays You a larger benefit than You should have received due to any and all causes, ReliaStar Life may recover any overpayments it made to You.

Any Minimum Monthly Income Benefit otherwise payable will not be paid until the overpayment is recovered.
H5102DS

Waiver of Premium
ReliaStar Life waives Your premium during any period for which benefits are payable. If ReliaStar Life waives Your premium it is the Policyholder's responsibility to refund to You any contribution You may make after qualifying for benefits.
H5103DS

Termination of Benefits
ReliaStar Life stops paying benefits on the earliest of the following:
- The date You are no longer disabled.
- The end of the Maximum Benefit Period for any one Period of Disability. The Maximum Benefit Period is shown on the Schedule of Benefits.
- The date You no longer qualify for benefits.
- The date of Your death.
- The date You fail to provide written proof of Disability that ReliaStar Life determines to be satisfactory.
- The date You cease to be under the Regular and Appropriate Care of a Doctor, or refuse to undergo an examination or testing by a Doctor of ReliaStar Life's choosing.
- The date You refuse to undergo vocational, functional or rehabilitation testing that ReliaStar Life requires.
- The date You refuse to provide satisfactory financial documentation as requested by ReliaStar Life or its administrator.

H5104DS

DISABILITY INCOME INSURANCE

Recurrent Disability
You will not be considered to have more than one Period of Disability at the same time. Successive periods of Disability will be considered a recurrent Disability if:
- Disability is due to the same or related cause; and
- Disability begins after You have been Actively at Work for less than [3-6] months.

A recurrent Disability is not subject to a new Benefit Elimination Period and benefits paid are treated as a continuation of the prior Period of Disability.

Benefits payable under this Recurrent Disability provision will stop if benefits are payable to You under any other group disability insurance policy obtained through [ABC Association].
H5105RD

Exclusions
ReliaStar Life will not pay benefits if Your Disability results from any of the following:
- [Sickness or] Injury which occurs in any armed conflict, whether declared as war or not, involving any country or government.
- [Sickness or] Injury that occurs while You are on military service for any country or government.
- Intentionally self-inflicted Injury [or Sickness], whether You are sane or insane.
- Injury that occurs due to Your active participation in a riot or insurrection, the provocation, commission or attempted commission of a felony or engagement in an illegal occupation.
- [Sickness or] Injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by [Sickness or] Injury.
- [Normal Pregnancy and childbirth, except complications of pregnancy.]
- [Sickness, disease, or bacterial infection except infection that results from an accidental injury, or infection that results from accidental, involuntary, or unintentional ingestion of a contaminated substance.]
- Being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Traveling or flying on an aircraft operated by or under the authority of the military or any aircraft being used for experimental purposes.

ReliaStar Life will not pay benefits for:
- any Injury [or Sickness] that is specifically excluded from coverage by Rider attached to this Certificate.
- the portion of any Period of Disability that You are confined in a penal or correctional institution as a result of a conviction for a criminal or other public offense.

H6332EX

ReliaStar Life will not pay an additional benefit for Disability caused [by both Sickness and Injury or] by more than one [Sickness or] Injury.
H6333EX

[Pre-Existing Condition Exclusion
ReliaStar Life will not pay Monthly Income Benefits if Your Disability is due to a Pre-existing Condition, and You became Disabled within [3,6,12,24] months of the date Your coverage became effective. [This exclusion does not apply if after the date your coverage becomes effective there is a period of [3,6,12] months or more during which you do not receive medical treatment, care, services or advice from a medical professional for Your Pre-existing Condition.]]
H6334EX

[Limitation for Mental Disorder, Alcoholism or Chemical Dependency
When disability is due to Mental Disorder, Alcoholism, or Chemical Dependency, ReliaStar Life limits Monthly Income Benefits payable to a maximum of [12,24] months.

This maximum applies to any and all such periods of Disability during Your lifetime.

If at anytime during the [12,24] month period, You are Hospital confined [or are participating in an approved treatment program] for the same Disability, ReliaStar Life pays benefits for as long as You remain Hospital confined [or participate in the approved treatment program,] up to the Maximum Benefit Period. After Your release from the Hospital [or the approved treatment program], ReliaStar Life continues payment of benefits for any remaining portion of the [12,24] months for which You are qualified to receive benefits under the terms of the Group Policy.]
H530ML

[Additional Benefits]

H905DS

[Accelerated Benefit
ReliaStar Life will pay a lump sum Accelerated Benefit to You if You:
- meet the definition of Total Disability under the Group Policy.
- are certified by a Doctor as having a life expectancy of less than [6-18] months.
- make a written request for this benefit.

ReliaStar Life may, at its option, confirm the terminal illness diagnosis with a second medical exam performed by a Doctor of its choosing at its own expense.

The Accelerated Benefit -
- will be an amount equal to the amount shown in the Schedule of Benefits.
- is payable to You only while You are living and no more than once per Your lifetime.
- is payable in addition to the Monthly Income Benefit Amount otherwise payable under the Group Policy.]

H5247DS

[Education Benefit
If You are Disabled and receiving Monthly Income Benefit payments under the Group Policy, You will receive the Monthly Education Benefit shown in the Schedule of Benefits for each child who is an Eligible Student. Benefits will be payable between terms as long as the Eligible Student is enrolled for the next scheduled term.

This Education Benefit will end on the earliest of the following:
- the date the child is no longer an Eligible Student.
- any other date Monthly Benefit payments would stop in accordance with the Group Policy.
- the date ReliaStar Life has paid [12-48] Monthly Education Benefits.

An Eligible Student is Your natural child, legally adopted child, stepchild, foster child, or any child who lives with You in a regular parent-child relationship, provided You claim the child as a dependent on Your most recent federal income tax return and provided the child is -
- under age [23],
- not married,
- not in the armed forces of any country,
- attends an accredited post-secondary school (other than a correspondence school) on a full-time basis as defined by the post-secondary school, and
- enrolled in the next scheduled term.

[Eligible Student will also include Yourself if, at the time that each Monthly Benefit payment for Your Disability becomes due, You are enrolled as an eligible post graduate student at an accredited post-secondary school (other than a correspondence school) on a full-time basis as defined by the post-secondary school.]

The Education Benefit is paid in addition to any other benefits You receive under the Group Policy.]
H5248DS

DISABILITY INCOME INSURANCE

[Human Immune Deficiency Virus Benefit
If You test positive for the Human Immune Deficiency Virus (HIV) and -
- ReliaStar Life receives proof of the results of any testing, as designated by the Centers for Disease Control and Study, that You would be deemed HIV positive, and
- as a result of a regulation, restriction, or modification of policy set by:
  – a licensing board,
  – the Center for Disease Control and Study,
  – the Occupational Safety and Health Administration,
  – a Hospital, clinic board or an employer,
  – any State or Federal Agency,
  the amount of time You can work or the duties of Your Own Occupation that You can perform are restricted to the extent that Your current Monthly Earnings are less than [40-80]% of Your [Indexed] Monthly Earned Income, and
- ReliaStar Life receives written documentation from a Doctor, clinic board, Hospital or Your employer barring You from performing one or more of the substantial and material duties of Your Occupation,

ReliaStar Life will presume that You are Totally Disabled. ReliaStar Life will pay the Monthly Benefit under this Benefit for up to the Maximum Benefit Period.

ReliaStar Life reserves the right to request its own testing as recommended by the Centers for Disease Control and Study.]
H5249DS

[Survivor Benefit
If You die during a Period of Disability for which Monthly Income Benefits were payable under the Group Policy, ReliaStar Life will pay to Your Beneficiary a one-time benefit amount equal to [3-24] times Your last full Monthly Income Benefit Payable, if You had been Disabled for at least 180 days on the date that death occurred.]
H541SU

[Normal Pregnancy
ReliaStar Life will pay a Monthly Income Benefit Payable if Your Disability is caused by normal pregnancy or childbirth if:
- Your Disability begins at least 10 months after the Effective Date of Your coverage; and
- Your pregnancy or childbirth results in Total Disability and is not due to a Complication of Pregnancy that is covered under the Group Policy.

You must complete the Benefit Elimination Period or be continuously Disabled for 90 days, whichever is greater, before benefits are payable.

Complications of Pregnancy are covered on the same basis as any other Sickness.]
H5106DS

[Infectious and Contagious Disease Benefit
ReliaStar Life will consider You Totally Disabled if You provide verification that:
- You carry an Infectious and Contagious Disease.
- You first tested positive for the Infectious and Contagious Disease after the Effective Date of Your Coverage shown on the Schedule of Benefits.
- You have never refused to be immunized against the Infectious and Contagious Disease for which You are claiming this benefit.
- One or more of the following has taken place -
  – Your license to practice Your Own Occupation has been revoked.
  – You or Your license have limitations or restrictions by a professional governing board or Your employer that prevent You from performing the Essential Duties of Your Own Occupation.
  – It has been disclosed that You are infected by an Infectious and Contagious Disease.

An Infectious and Contagious Disease means a disease that is:
- Categorized by the Center of Disease Control as infectious and contagious.
- Life threatening to You, or to persons with whom You may come in contact with and infect in the performance of Your Own Occupation.

ReliaStar Life will pay the Monthly Income Benefit under this Benefit for up to the Maximum Benefit Period for Total Disability.]
H5110DS

[Self-Reported Symptoms Benefit
If You are Disabled primarily due to one or more of the Self-Reported Injuries or Sicknesses defined in this Certificate, ReliaStar Life will presume that You are Totally Disabled. ReliaStar Life will pay the Monthly Income Benefit under this Benefit for up to 24 months for one Period of Disability unless You are Hospital confined. Monthly Income Benefits will continue if Hospital confined until the earlier of the date -
- You are discharged from the Hospital; or
- You reach the Maximum Benefit Period for Total Disability.]

H5448DS

[Worksite Modification Benefit
If ReliaStar Life's vocational rehabilitation specialist's review of Your file determines that:
- a worksite modification would help You remain at work or return to Any Gainful Occupation; and
- You and/or Your employer and ReliaStar Life mutually agree upon the worksite modification in a written agreement signed by You and/or Your employer and ReliaStar Life,

ReliaStar Life will reimburse You or Your employer, as determined by ReliaStar Life, for the cost of the modification, not to exceed the lesser of:
- $5,000.
- Two times Your Monthly Income Benefit.

This benefit is payable only once in Your lifetime. You must be Disabled and receiving the Monthly Income Benefit under the Group Policy to be considered for this benefit.]
H5447DS

Rehabilitation Program
If, while you are Totally Disabled, You accept Rehabilitative Employment, ReliaStar Life will continue to pay the Monthly Income Benefit. The benefit payable will be equal to Your Monthly Income Benefit, less 50% of any income received from Rehabilitative Employment. The sum of the Monthly Income Benefit and total income received from Rehabilitative Employment may not exceed 100% of Your Monthly Earned Income. If this sum exceeds 100% of Your Monthly Earned Income, the Monthly Income Benefit will be reduced by the excess amount.

At the end of every 6 month period, ReliaStar Life reserves the right to review any Rehabilitative Employment in which You participate while being paid benefits for Total Disability.

If You remain Totally Disabled after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit, subject to the Maximum Benefit Period.

Rehabilitative Employment is any employment or service which -
- prepares a Totally Disabled person to resume Any Gainful Occupation, and,
- is approved, in writing, by ReliaStar Life.

H552RW

[Residual Disability Benefit

If You are Residually Disabled, ReliaStar Life will pay You a Monthly Benefit Amount for each month of Your Residual Disability up to the Maximum Benefit Period. Payments for a combined period of Total Disability and Residual Disability will not exceed the Maximum Benefit Period shown on the Schedule of Benefits.

The Residual Disability benefit will be payable on the first day after Your continuous period of [Total] Disability satisfies the Benefit Elimination Period shown in the Schedule of Benefits.

Your Residual Disability Monthly Benefit is determined as follows:

(A divided by B) multiplied by C, where
A is Your [Indexed] Monthly Earned Income minus Your Current Monthly Earned Income.
B is Your [Indexed] Monthly Earned Income.
C is the Monthly Benefit Payable if You were Totally Disabled.

Current Monthly Earned Income means the earnings You receive while You are Disabled and working, plus the earnings You could receive if You were working to Your maximum capacity for each month You are Residually Disabled.]
H5111DS

[Continuous Period of Disability
In no event will You be considered to have more than one Disability, Total or Residual, at the same time. Once a period of continuous Disability begins, ReliaStar Life will consider it to be one Period of Disability regardless of what [Sickness or] Injury causes it to continue.

A continuous Period of Disability ends when You are no longer Disabled. A later separate Period of Disability will be considered continuous if it is a recurrent Disability.

If Periods of Disability are considered continuous, they count as a single period. If a Disability is not continuous, You must meet a new Benefit Elimination Period and a new Maximum Benefit Period will apply.]
H5113DS

[Benefit Termination
Benefit payments for a Residual Disability will cease on the first to occur of:
- the date the Maximum Benefit Period ends.
- the date Your Disability Earnings exceed [75,80]% of Your [Indexed] Monthly Earned Income.
- the date You are eligible for benefits under the Total Disability Benefit due to the same or related causes.]

H5250DS

CLAIM PROCEDURES

C90CP

Notice of Claim
You or someone on Your behalf must send ReliaStar Life written notice of the loss on which the claim will be based. The notice must –
- include information to identify You, such as Your name, address and Group Policy number.
- be sent to ReliaStar Life or to its authorized administrator.
- be sent within 20 days after the loss for which claim is based has occurred or as soon as reasonably possible.

Claim Forms
ReliaStar Life or its authorized administrator will send claim forms to You. ReliaStar Life will send the forms within 15 days after ReliaStar Life receives notice of claim.

Proof of Loss
The completed claim forms must be returned to ReliaStar Life or its authorized administrator within 90 days after the Benefit Elimination Period. Even if You do not receive claim forms, written proof of loss must be sent to ReliaStar Life within 90 days after the Benefit Elimination Period. If You are not able to send proof of loss within the required 90 day time period, You must send it as soon as reasonably possible. In no event, except if You are legally incapacitated, will proof of loss be accepted later than one year from the date proof of loss is required.

Written proof of loss includes details of how the loss occurred. ReliaStar Life may require further documentation to verify proof of loss You submitted and to determine Your eligibility to receive benefits and to compute the benefits due.

ReliaStar Life reserves the right to have You examined at no cost to You by doctors or specialists to determine the extent of Your restrictions and limitations caused by [Sickness or] Injury. ReliaStar Life may also require that You meet in person with a ReliaStar Life representative.
H7164CP

Benefit Payments
Benefits under the Group Policy are paid when proof of loss is received.

Benefits are paid to You. Any Monthly Income Benefit Payable remaining unpaid at the time of Your death will be paid to Your survivors or Your estate in the following order:
[1. Your Beneficiary, if applicable.
2. Your spouse.
3. Your children.
4. Your estate.]
H7165CP

Time of Payment of Claims
Subject to due proof of loss, all accrued benefits payable under the Group Policy will be paid at the end of each month during the period for which ReliaStar Life is liable. Any balance remaining unpaid at the end of such period will be paid as soon as possible after receipt of written proof of loss.
H7166CP

PREMIUMS

H98DS

Premium Due Date
The first premium is due on Your Effective Date of coverage shown on the Schedule of Benefits. Each premium after that is due at the end of the period for which Your preceding premium was paid.
H718DS

Individual Grace Period
You have a 31 day grace period for the payment of each premium due after the first premium. Your coverage will continue in force during Your grace period. Your coverage will terminate at the end of Your grace period if all premiums then due are not paid by You.
H719DS

GENERAL PROVISIONS

C90GP

Assignment
You may not transfer ownership of any certificate issued under the Group Policy to anyone else.
H7196GP

Legal Action
Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements stated in the Claims Procedures section of this Certificate. Legal action must be taken within 3 years after the date proof of loss must be submitted.

If the Policyholder's state requires longer time limits, ReliaStar Life will comply with the state's time limits.
H7197GP

Exam
When reasonably necessary, ReliaStar Life may have You examined while You are claiming benefits. The exam may be conducted by one or more Doctors or functional or vocational experts of ReliaStar Life's choice. The exam may include vocational testing and evaluations, or any other type of testing and evaluations ReliaStar Life determines necessary. This right will only be exercised as often as ReliaStar Life reasonably believes necessary to properly evaluate Your claim and Your potential for rehabilitation. ReliaStar Life has the right to defer or suspend payment of benefits if You fail to attend an exam or fail to cooperate with the Doctor. Benefits may be resumed, provided that the required exam occurs within a reasonable time and benefits are otherwise payable.
H7198GP

Incontestability
Any statement You make to obtain insurance or an increase in insurance is a representation and not a warranty. No misrepresentation by You will be used to reduce or deny a claim or to deny the validity of Your insurance or an increase in insurance unless all of the following are true:
- Your insurance or increase in insurance would not have been approved if the truth had been known.
- Your misrepresentation is contained in a written instrument signed by You.
- You or Your Beneficiary, if applicable, have been given a copy of the written instrument containing Your misrepresentation.

After Your insurance or increase in insurance under the Group Policy has been in effect for two continuous years during Your lifetime, ReliaStar Life will not use a misrepresentation by You to reduce or deny a claim or to deny the validity of Your insurance or increase in insurance unless it was a fraudulent misrepresentation. However, ReliaStar Life has the right at any time to assert as a defense to a claim that You were not eligible for coverage or for the increase because You did not meet the requirements of the Group Policy. These requirements include, but are not limited to, any requirements that You satisfy the eligibility requirements and submit and have approved proof of good health[, except if a Transition Rider is attached to this Certificate].
H7199GP

GENERAL PROVISIONS

Reimbursement
If ReliaStar Life pays Monthly Income Benefits for [Sickness or] Injury caused in whole or part by the act or omission of another, You must –
- reimburse ReliaStar Life for the benefits paid if You recover damages for lost income by settlement, court order, judgment or otherwise.
- provide ReliaStar Life with a lien and order directing reimbursement for benefits. The lien and order may be filed with –
  – the person whose act caused the [Sickness or] Injury.
  – their agent.
  – the court.
  – Your attorney.
- cooperate with ReliaStar Life, including execution, completion, and filing of any document deemed by ReliaStar Life necessary to protect its reimbursement rights.

ReliaStar Life has a first priority claim against –
- amounts which are or may be subject to reimbursement.
- any person who is or may be obligated to pay damages for lost income. This includes any insurer of You.

ReliaStar Life will be reimbursed first before other claims against amounts recovered or recoverable from persons who are or may be obligated to pay damages for lost income, even if the amounts are not enough to reimburse ReliaStar Life in full or compensate You in full for damages sustained.

ReliaStar Life has no obligation to pay attorney's fees or other legal fees to Your attorney for recovery of amounts subject to reimbursement.

ReliaStar Life will have the right to intervene in any suit or other proceedings to protect its reimbursement rights. Any settlement proceeds received by You or Your attorney will be held in trust for ReliaStar Life's benefit. ReliaStar Life's rights herein are binding upon and enforceable against Your legal representatives, heirs, next of kin, and successors in interest.
H7200GP

Subrogation
If ReliaStar Life pays Monthly Income Benefits for [Sickness or] Accidental Injury caused in whole or part by the act or omission of another, ReliaStar Life will have a right of subrogation against any person, any insurer, You or any insurer of You, should You receive, or have a right to receive, any damages or payments.

You will do nothing to prejudice ReliaStar Life's subrogation rights and will cooperate with ReliaStar Life to protect such rights. This includes –
- providing information.
- signing an agreement documenting ReliaStar Life's subrogation rights.
- taking other action ReliaStar Life requests. This includes execution, completion, and filing of any document deemed by ReliaStar Life necessary to protect its rights.

ReliaStar Life's subrogation rights and amounts recoverable or recovered pursuant to such rights are a first priority claim. Such amounts will be reimbursed first even if all amounts recovered from whatever source are insufficient to compensate You in part or whole for all damages sustained.

At ReliaStar Life's option, action may be taken to preserve its subrogation rights. This includes –
- the right to bring any legal action in Your name.
- seeking reimbursement out of any amount from any source recovered by You.

Any proceeds will be proportionately adjusted for the costs and legal fees You incur to recover from the third party.

Any settlement proceeds received by You, or Your attorney will be held in trust for ReliaStar Life's benefit. ReliaStar Life will have the right to intervene in any suit or proceeding to protect its subrogation rights. ReliaStar Life's rights herein are binding upon and enforceable against Your legal representatives, heirs, next of kin, and successors in interest.
H7309GP

GENERAL PROVISIONS

Consumer Notice
The nearest servicing office is the Minneapolis, Minnesota office of ING Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.

The mailing address is:
P.O. Box 20
Minneapolis, Minnesota 55440-0122

Telephone: [(800) 537-5024]

If You are not provided reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
(Corner of Third and Cross Street)
Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640
Toll Free: (800) 852-5494
H7310GP

DEFINITIONS

C90DF

Active Work, Actively at Work – the Member is physically present at his or her customary place of employment with the intent and ability of working at least [30] hours per week and performing the normal duties of his or her Own Occupation.
H8805DF

[Alcoholism – a disorder of psychological and/or physiological dependence or addiction to alcohol which results in functional (physical, cognitive, mental, affective, social or behavioral) impairment.]
H8187DF

Any Gainful Occupation – an occupation for which you are qualified by education, training or experience that is or can be expected to provide You with an income at least equal to Your gross disability benefit within 12 months of Your return to work that exceeds [60-80]% of Your [Indexed] Monthly Earned Income.

The following factors will be considered:
- Your past training, as well as training You could receive.
- Your education and experience.
- Your physical and mental capacity.

H8961DF

Beneficiary – the person named in ReliaStar Life's records to receive any benefit payable under this Group Policy at the time of Your death. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless You designated otherwise.
H8806DF

[Chemical Dependency – a disorder of psychological and/or physiological dependence or addiction to psychoactive drugs or medications, legal or illegal, which results in functional (physical, cognitive, mental, affective, social or behavioral) impairment.]
H8807DF

[Chronic Fatigue Sickness – a sickness that is characterized by a debilitating fatigue, in the absence of other known medical or psychological conditions. It includes, but is not limited to:
- a chronic fatigue syndrome or chronic fatigue immunodeficiency syndrome.
- an Epstein-Bass or herpes 6 viral infection, or post viral syndrome.
- Limbic encephalopathy or myalgic encephalomyelitis.

It does not include depression or any neoplastic, neurologic, endocrine, hematologic or rheumatologic disorder.]
H81069DF

[Complications of Pregnancy – the conditions, occurrences and procedures including ectopic pregnancy, spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible, and non-elective Cesarean Section. Conditions that are not complications include conditions, occurrences or procedures associated with morning sickness, false labor, or Doctor prescribed rest during the period of pregnancy and similar conditions, occurrences and procedures associated with the management of a difficult pregnancy which are not a categorically distinct Complication of Pregnancy.]
H8808DF

Current Monthly Earnings – the monthly earnings You receive from Your employer while You are Disabled.
H8962DF

DEFINITIONS

Disability, Disabled – due to Total Disability [Residual Disability,] [or being Catastrophically Disabled,] You are prevented from performing one or more of the Essential Duties of:
- Your Own Occupation during the Benefit Elimination Period.
- Your Own Occupation following the Benefit Elimination Period, and as a result Your Current Monthly Earnings are less than [40-80]% of Your [Indexed] Monthly Earned Income.

Your Disability must result from one of the following:
- Injury [or Sickness].
- Alcoholism, Mental Illness or Chemical Dependency.]
- Pregnancy.]

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Own Occupation alone does not mean that You are Disabled.
H8809DF

Doctor – a medical practitioner of a healing art which is recognized by applicable state law, who meets all of the following conditions:
- He or she is practicing within the scope of his or her license.
- He or she is certified or credentialed by the appropriate medical or professional board that provides certification or credentialing for practitioners who perform the type of treatment or service the practitioner is providing for Your [Sickness or] Injury.
- He or she possesses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat Your condition.

The term Doctor does not include You, anyone related to You by blood or marriage, anyone living in Your household, or anyone working for Your employer or business entity.
H8810DF

Essential Duties – duties that:
- are substantial and not incidental,
- are fundamental or inherent to the occupation, and
- cannot be reasonably omitted or changed.

If you were normally required to perform Essential Duties in excess of 40 hours per week prior to becoming disabled, ReliaStar Life will consider You still able to perform the Essential Duties if You are working or have the capacity to perform such duties at least 40 hours weekly.
H8812DF

[Environmental Sickness – an allergy or sensitivity to chemicals or the environment. It includes, but is not limited to:
- Environmental allergies.
- Sick building syndrome.
- Multiple chemical sensitivity syndrome.
- Chronic toxic encephalopathy.

It does not include asthma or allergy-induced reactive lung disease.]
H81070DF

DEFINITIONS

Group Policy – the written group insurance contract between ReliaStar Life and the Policyholder.
C83DF

Hospital – an institution licensed as a hospital in the state in which it is located, which meets the following conditions:
- Provides, for a fee from its patients, diagnostic, medical, surgical, psychiatric or rehabilitative services for the care and treatment of people who are injured or sick.
- Has a staff of one or more doctors available at all times.
- Has 24-hour-a-day services of R.N.'s or other nursing services reporting to the doctor in charge.
- Has inpatient facilities.
- Is accredited by one of the following:
  – The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
  – American Osteopathic Hospital Association (AOHA).
  – American Osteopathic Association (AOA).
  – Commission on Accreditation of Rehabilitation Facilities (CARF).

H8193DF

Hospital is not an institution that is mainly a rest home, extended care facility or home for the aged.
H818DF

Hospital Confined – admitted to and confined in a Hospital on an inpatient basis for a period of 24 hours or more.
H8635DF

[Indexed – in determining Disability [and Residual] benefits, Your Monthly Earned Income is increased on the one-year anniversary of your first benefit and on each yearly anniversary thereafter. The amount of the increase will be the lesser of [5-10]% or the increase in the Consumer Price Index for all Urban Wage Earners and Clerical Workers (CPI-W).]
H81087DF

Injury – bodily Injury resulting directly from an accident and independent of all other causes. [If You become Disabled because of an Injury more than 365 days after the event causing the Injury, ReliaStar Life pays benefits as if Your Disability was caused by sickness.]
H8813DF

[Leave of Absence – You are absent from Your Own Occupation for a period of time that has been agreed to in advance in writing by Your employer. Normal vacation time or any Period of Disability is not considered a Leave of Absence.]
H81071DF

Maximum Capacity – based on Your restrictions and limitations:
- During the Benefit Elimination Period and the [first] [24,60] months of payments [thereafter], the greatest extent of work You are able to do in Your Own Occupation.
- [After [24,60] months of payments, the greatest extent of work You are able to do in any occupation for which You are reasonably fitted by education, training or experience.]

H8964DF

Member – [an active Member of the Policyholder who is a citizen or a legal resident of the United States or its territories.]
H8814DF

[Mental Disorder – any sickness, disease or disorder for which both of the following are true:
- It is listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association.
- It is standardly treated by a qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. A qualified provider means a duly licensed and/or certified professional who specializes in the diagnosis, treatment and prevention of mental disorders, alcoholism or chemical dependency.

A mental disorder includes any such condition whether or not related to an underlying physical, genetic, chemical, organic or biological cause, and even though it may be associated with physical symptoms, manifestations or expressions. Specific mental disorders would include, but are not limited to, bipolar disorders, depression and depressive disorders, stress disorders including post-traumatic stress disorders, somatoform disorders, factitious disorders and eating disorders. It does **not** include coma (unless as a consequence of substance abuse), Alzheimer's Disease, mental retardation or dementia with an identifiable organic basis.]
H8642DF

Monthly Earned Income –
[for sole proprietors, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or shareholders in a S-Corporation, Monthly Earned Income includes the monthly average of the sum of the following amounts as reported on the applicable Schedule K-1, Schedule C, Form W-2 or S-Corporation federal income tax return:
• Your ordinary business income or loss.
• Your guaranteed payments, if You are a partner.
• Your net profit or loss from business.
• Your compensation as an officer, salary, or wages, if You are a shareholder in a S-Corporation.

The monthly average will be based on:
• the [2,3] tax year(s) just prior to the date of Disability; or
• the number of months You were employed in this capacity, if less than the above period.
[• Contributions You make through a salary reduction agreement with Your employer to:
– an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement.
– an executive non-qualified deferred compensation arrangement.
– a salary reduction arrangement under an IRC Section 125 plan.
for the same period as above.]

Monthly Earned Income does not include bonuses, commissions, tips and tokens, dividends, capital gains and returns of capital.]

[for Members, Your average monthly rate of pay including Bonuses, Commissions and Tips and Tokens from Your employer for the [2,3] tax year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period.

[Monthly Earned Income includes:
• Contributions You make through a salary reduction agreement with Your employer to:
– an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement.
– an executive non-qualified deferred compensation arrangement.
– a salary reduction arrangement under an IRC Section 125 plan.]

Monthly Earned Income [does not] include [bonuses, commissions, tips and tokens,] overtime pay or expense reimbursements for the same period as above.]

[for Teachers, Your annual salary (excluding overtime and bonuses) divided by 12. During a Leave of Absence, Monthly Earned Income means Your annual salary (excluding overtime and bonuses) immediately prior to such leave, divided by 12.]
H8815DF

[Musculoskeletal/Connective Tissue Injury or Sickness – includes, but is not limited to:
• Scoliosis that does not require surgery.
• Any other disease or disorder of the cervical, thoracic, or lumbosacral back and surrounding soft tissue, unless documented by x-ray, electromyogram, computerized tomography or magnetic resonance imaging.
• Sprains or strains of the muscles, joints and adjacent tissues.
• Fibromyalgia, carpal tunnel syndrome, or repetitive motion syndrome.
• Myofacial pain, or any craniomandibular or temporomandibular joint disorder (TMJ).

It does not include:
- Scoliosis that requires surgery, or spondylolisthesis of grade II or higher.
- Radiculopathies or herniated discs that are documented by x-ray, electromyogram, computerized tomography or magnetic resonance imaging.
- Tumors, malignancies, vascular malformations or osteopathies.
- Lupus, or rheumatoid or psoriatic arthritis.]

H81072DF

Own Occupation – the occupation or profession which You are regularly engaged at the time You become Disabled. ReliaStar Life will look at Your occupation or profession as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location. [However, if Your occupation or profession is limited to a recognized specialty within the scope of Your degree or license, ReliaStar Life will deem Your specialty to be Your occupation or profession.]

[If You are a [Doctor] [Dentist], Your occupation or profession means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the [American Board of Medical Specialties]. If the sub-specialty in which You are practicing is not recognized by the [American Board of Medical Specialties], You will be considered practicing in the general specialty category. In addition, You must carry malpractice insurance covering the full range of duties performed in this specialty or sub-specialty and for the [24] months immediately prior to Disability, at least 60% of Your Monthly Earned Income was professional service fee income attributable to the practice of this specialty or sub-specialty.]

[If You are an attorney, Your occupation or profession means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your occupation or profession means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]

H81073DF

Period of Disability – a new period of disability begins if the new disability results from a cause or causes unrelated to that of any previous disability, separated by active work. All periods of disability which have the same cause are considered one period of disability unless separated by a return to full-time Active Work for at least [3-6] months.

H8816DF

Policyholder – [ABC Association].

C86DF

[Pre-existing Condition – a [Sickness or] Injury for which, during the [3,6,12] months immediately before the effective date of Your insurance or increased amount of insurance, You did one or more of these:
- Received medical treatment, care, services or advice from a medical professional.
- Experienced related or resulting symptoms or aggravations which would be a reasonable cause a person to seek diagnosis, care or treatment from a Doctor or health care facility.]

H8817DF

Regular and Appropriate Care – means:
- You personally visit a Doctor as often as is medically required, according to generally accepted medical standards and consistent with the stated severity of Your medical condition, to effectively manage and treat Your [Sickness or] Injury.
- You are receiving care which conforms with generally accepted medical standards for treating Your [Sickness or] Injury and is consistent with the stated severity of Your medical condition.
- Care is rendered by a Doctor whose specialty or experience is the most appropriate for Your disability according to generally accepted medical standards.

H8818DF

ReliaStar Life – ReliaStar Life Insurance Company, at its Home Office in Minneapolis, Minnesota.

C85DF

DEFINITIONS

[Residual Disability – while You are working to Your Maximum Capacity due to Injury [or Sickness]:
- You are unable to perform some or all of the duties of Your Own Occupation or any other occupation.
- You are working in Your Own Occupation or another occupation.
- You have an income loss of at least [20,25]% of Your [Indexed] Monthly Earned Income.
- You are receiving Regular and Appropriate Care.]

H8820DF

[Self-Reported Injury or Sickness – any Chronic Fatigue Sickness, Environmental Sickness, or Musculoskeletal/Connective Tissue Injury or Sickness.]
H81075DF

[Sickness – any physical illness, Mental Disorder, or Complication of Pregnancy that begins after the Effective Date shown on the Schedule of Benefits. Normal Pregnancy is [not] considered a Sickness.]
H8821DF

[Total Disability, Totally Disabled – due to Injury [or Sickness]:
- During the Benefit Elimination Period [and the following [24,60] months], [and thereafter], You are unable to perform the Essential Duties of Your Own Occupation. [After [24,60] months of benefits, You are unable to perform the Essential Duties of Any Gainful Occupation for which You are qualified by education, training or experience.]
- You have an income loss of at least [0-40]% of Your [Indexed] Monthly Earned Income and are not working in Any Gainful Occupation.
- [• You are not Residually Disabled.]
- You must be receiving Regular and Appropriate Care.

You will not be considered Disabled solely because of the loss or restriction of Your license to engage in Your Own Occupation.]
H8823DF

[Total Disability – if school is in session, You are disabled when ReliaStar Life determines that You are unable to perform the Essential Duties of Your Own Occupation due to Your [Sickness or] Injury and You are not working in Any Gainful Occupation. If school is not in session, You are Disabled when ReliaStar Life determines that You would be unable to perform the Essential Duties of Your Own Occupation due to Your [Sickness or] Injury if school were in session and You are not working in Any Gainful Occupation.]
H81076DF

Written, In Writing – signed, dated and received at ReliaStar Life's Home Office in a form ReliaStar Life accepts.
H8824DF

You, Your – a Member of the Policyholder insured under the Group Policy.
H8825DF

SCHEDULE OF BENEFITS

DISABILITY INCOME INSURANCE

Insured Person: ..... [John Doe]

Effective Date of Your Coverage ..... [April 1, 2011]

[Group Policy Number: ..... GH-12345-6]

[Other identifying information required by ReliaStar Life or its Administrator ..... Additional Info]

Maximum Monthly Income Benefit ..... $[1,000-25,000]

[Accidental Death and Dismemberment Benefit Rider ..... **Principal Sum $1,000-$100,000]**

[Additional Benefits	**Benefit Amount]**
[Accelerated Benefit	
Lump Sum Benefit	[25-75]% of Monthly Income Benefit times [1-12] months]
[Assisted Living Benefit Rider - Stated Benefit	
Assisted Living Monthly Benefit	$[500-5,000] not to exceed Monthly Income Benefit for Total Disability
Extended Assistant Living Lump Sum Benefit	[1-3] times the Monthly Income Benefit]
[Assisted Living Benefit Rider - Percentage Benefit	
Percentage of Gross Disability Payment	[25-75]% of Gross Disability Payment
Extended Assisted Living Lump Sum Benefit	[1-3] times the Monthly Income Benefit]
[Business Overhead Expense Total Disability Benefit Rider	
Maximum Monthly Benefit Amount	$[1,000-15,000]
Benefit Elimination Period	[30-60] Days
Maximum Benefit Period	[12-24] Months]
[Cost of Living Adjustment Rider	See Rider]
[Education Benefit	
Monthly Education Benefit per child	$[100-3,000]]
[Guaranteed Purchase Option Rider	
Option Date Increase	[3-25]%]
[Hospital Income Benefit Rider	
Daily Benefit Amount	$[100-500]
Maximum Payment Period	[180-365] Days]
[Human Immune Deficiency Virus Benefit	See Benefit]
[Infectious and Contagious Disease Benefit	See Benefit]
[Normal Pregnancy Benefit	See Benefit]
[Recovery Benefit Rider	See Rider]
[Residual Disability Benefit	
Monthly Income Benefit	$[1,000-25,000]]
[Retroactive Benefits	See Benefit]
[Retroactive Benefits for Hospital Confinement	See Benefit]
[Self-Reported Symptoms Benefit	See Benefit]
[Spouse/Domestic Partner Disability Income Insurance Benefit Rider]	[$1,000-25,000]
[Survivor Benefit	See Benefit]
[Worksite Modification Benefit	See Benefit]

Total Disability [Residual Disability] [Catastrophic Disability] Benefit Elimination Period - Your Benefit Elimination Period is [30] [60] [90] [180] [365] Days.

Total Disability [Residual Disability] [Catastrophic Disability] Maximum Benefit Period - [2 years] [5 years Accident/2 years Sickness] [5 years] [10 years] [to age 65] [to age 70]

SCHEDULE OF BENEFITS

Maximum Benefit Period
The Maximum Benefit Period reduces at certain ages and is determined from the following schedule based on Your age on the date You are Disabled. On or after age 61, the Maximum Benefit Period is the lesser of Your Maximum Benefit Period or the Benefit duration shown below.

Age at disability	**Maximum benefit period**
• Less than 61	[2 years] [5 years Accident/2 years Sickness] [5 years] [10 years] [to age 65] [to age 70]
• 61	[48 months]
• 62	[36 months]
• 63	[24 months]
• 64	[24 months]
• 65	[24 months]
• 66	[24 months]
• 67	[24 months]
• 68	[24 months]
• 69	[24 months]

Premiums

Initial Annual Premiums guaranteed until [DATE]	**Premiums**
Disability Income Insurance [with Residual]	$[XX]
[Accidental Death and Dismemberment Benefit Rider]	[$XX]
[Assisted Living Benefit Rider - Stated Benefit	$XX]
[Assisted Living Benefit Rider - Percentage Benefit	$XX]
[Business Overhead Expense Benefit Rider	$XX]
[Cost of Living Adjustment Rider	$XX]
[Guaranteed Purchase Option Rider	$XX]
[Hospital Income Benefit Rider	$XX]
[Recovery Benefit for Total Disability Rider	$XX]
[Spouse/Domestic Partner Disability Income Rider]	[$XX]

TOTAL PREMIUM

Annual	**Semiannual**	**Quarterly**	**Monthly**
[$XX]	[$XX]	[$XX]	[$XX]

[Additional Riders Attached at Issue:]

[Specified Condition Rider]

[Transition Rider]

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER

ReliaStar Life will pay the benefit shown in the Table of Losses if You sustain an Injury and as a direct result You suffer a loss described below. Any loss must take place within [90-365] days of the accident.

Table of Losses	**Benefit Payable**
Loss of life	The Principal Sum
Loss of both hands, both feet or sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and sight of one eye	The Principal Sum
[Loss of speech and hearing	The Principal Sum]
[Quadriplegia	The Principal Sum]
[Paraplegia	¾ The Principal Sum]
[Hemiplegia	½ The Principal Sum]
[Triplegia	½ The Principal Sum]
[Uniplegia	½ The Principal Sum]
Loss of one leg or one arm	½ The Principal Sum
Loss of one hand or one foot or sight of one eye	½ The Principal Sum
Loss of speech or hearing	½ The Principal Sum
Loss of thumb and index finger of same hand	¼ The Principal Sum

Loss of sight means the total and irrecoverable loss of sight. **Loss of one leg or one arm** means the actual severance through or above the knee or elbow joint. **Loss of hands or feet** means severance at or above the wrist or ankle. **Loss of thumb and index finger** means the actual, complete and permanent severance through or above the metacarpophalangeal joints. Loss of hand, foot, leg, arm, thumb and index finger must be total and irrecoverable and cannot be restored or corrected by medical or surgical treatment. **Loss of speech** means the total and irrecoverable loss of speech. **Loss of hearing** means the total and irrecoverable loss of hearing.

[Quadriplegia means total and permanent Paralysis of all four limbs.] **[Paraplegia** means total and permanent Paralysis of both lower limbs.] **[Uniplegia** means total and permanent Paralysis of one limb.] **[Triplegia** means total and permanent Paralysis of three limbs.] [**Hemiplegia** means total and permanent Paralysis of one arm and one leg on the same side of the body.]

[Paralysis means the permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb.]

The total amount payable for all losses You suffer as a result of any one Injury will not be more than the Principal Sum. The Principal Sum is shown in the Schedule of Benefits.

Accidental Death and Dismemberment Exclusions
In addition to General Exclusions, ReliaStar Life will not pay Accidental Death and Dismemberment benefits for a loss caused directly or indirectly by -
- Disease, bodily or mental infirmity, or medical or surgical treatment of these.
- Driving while intoxicated, as defined by the applicable state law where the loss occurred.

- Engaging in the following hazardous activities:
  – skydiving.
  – hang gliding.
  – auto racing.
  – dirt bike riding.
  – mountain climbing.
  – Russian Roulette.
  – autoerotic asphyxiation.
  – bungee jumping.
  – use of off-road vehicles.

In the section entitled CLAIMS PROCEDURES, the provision entitled Benefit Payments is amended as follows.

Covered benefits for any Accidental Dismemberment will be paid to You upon ReliaStar Life's satisfactory proof of loss.

Covered benefits payable for Your loss of life will be paid immediately to the beneficiary upon receipt of satisfactory proof of loss. The beneficiary is the person(s) You designate to receive any benefit payable because of Your death. The designation must be made in a written statement on a form approved by ReliaStar Life. The written statement must be placed on file with ReliaStar Life or its designated administrator.

You may change beneficiaries at any time, subject to applicable law. To do so, You must provide a written statement on a new form. The form changing the beneficiary must be given to ReliaStar Life or its designated administrator.

Any designation or change of beneficiary will be effective on the date of its execution, regardless of whether or not You are living at the time it is given to ReliaStar Life or its designated administrator. In the event You die before any designation or change is recorded, any benefit for loss of life ReliaStar Life may have already paid will be deducted from the amount payable to a newly named beneficiary.

If You designate more than one person to share any death benefit, You should specify on the form how the benefit is to be divided among them. Otherwise, they will share the benefit equally. All rights of any beneficiary cease if he or she dies before You do.

If for all or part of Your insurance no beneficiary has been properly designated in accordance with the Group Policy provisions and applicable law, the amount of Your insurance for which there is no beneficiary will be payable to Your estate.

If You and the beneficiary die from the same accident and the order of benefits cannot be determined, ReliaStar Life will pay the benefit as though you survived the beneficiary.

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

Executed by ReliaStar Life Insurance Company at its Home Office in Minneapolis, Minnesota.

Joy M. Benner

Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

ASSISTED LIVING BENEFIT RIDER
Stated Benefit Amount

Assisted Living Benefit
ReliaStar Life will pay the Assisted Living Benefit Amount for each month You are Catastrophically Disabled provided -
- Your Catastrophic Disability continues beyond the end of the Benefit Elimination.
- You are receiving Regular and Appropriate Care.

ReliaStar Life will not pay this benefit for any part of a period of Catastrophic Disability that -
- is applied to the Benefit Elimination Period at the onset of a Disability.
- continues beyond the end of the Maximum Benefit Period for Disability.

The Monthly Income Benefit is payable to You for Total Disability.

ReliaStar Life must receive proof that Your Disability is a Catastrophic Disability, as defined. You will no longer be eligible to receive this benefit on the date You are no longer Catastrophically Disabled.

The Benefit is paid in addition to Your Monthly Income Benefit under the Total Disability Benefit. The Assisted Living Monthly Benefit amount is shown in the Schedule of Benefits.

The Assisted Living Benefit ends on the earlier of:
- The date You no longer satisfy the criteria for the Assisted Living Benefit.
- The date Your Monthly Income Benefits for Total Disability terminate, subject to the Extended Assisted Living Benefit provision.

Termination or amendment of Your coverage under the Group Policy or under this Assisted Living Benefit Rider will not prejudice a claim in effect at the time of such termination.

Extended Assisted Living Benefit
If, on the date that You reach Your Maximum Benefit Period under the Total Disability Benefit when benefits are no longer payable for the Disability, You are still Catastrophically Disabled, ReliaStar Life will pay You an Extended Assisted Living Lump Sum Benefit. The Extended Assisted Living Lump Sum Benefit is shown in the Schedule of Benefits. [If You are also insured under the Cost of Living Adjustment Rider, the cost of living adjustment [will] [will not] apply to the Extended Assisted Living Lump Sum Benefit shown in the Schedule of Benefits.]

Definitions

Activities of Daily Living -
- Bathing - the ability to wash oneself in a tub or shower or by sponge bath, with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs normally worn.
- Toileting - the ability to get to and from the toilet, get on and off the toilet, perform associated personal hygiene and to care for clothing.
- Transferring - the ability to move into or out of a bed or chair with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices including mechanical or motorized devices.
- Continence - the ability to maintain control of bowel and bladder functions, or when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene including caring for a catheter or colostomy bag.
- Eating - the ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Catastrophically Disabled - due to Disability that begins while You are covered under this Benefit, You are:

- confined in a Hospital or similar institution and such confinement is expected to be permanent according to competent medical opinion;
- unable to perform [2,3] or more Activities of Daily Living without hands on or standby assistance because of physical or mental impairment; or
- Cognitively Impaired.

Cognitively Impaired - a loss or deterioration in intellectual capacity that is:

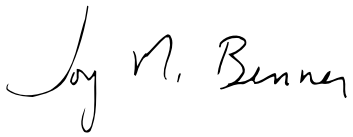
- comparable to (and including) Alzheimer's disease and similar forms of irreversible dementia; and
- is measured by clinical evidence and standardized tests approved by ReliaStar Life that reliably measure impairment in short-term or long-term memory, orientation as to people, places or time, and deductive or abstract reasoning.

Cognitively Impaired does not include loss or deterioration as the result of a Mental Disorder.

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

Executed by ReliaStar Life Insurance Company at its Home Office in Minneapolis, Minnesota.



Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

ASSISTED LIVING BENEFIT RIDER
Percentage Benefit

Assisted Living Benefit
ReliaStar Life will pay the Assisted Living Benefit Amount for each month You are Catastrophically Disabled provided -
- Your Catastrophic Disability continues beyond the end of the Benefit Elimination Period for Total Disability.
- You are receiving Regular and Appropriate Care.

ReliaStar Life will not pay this benefit for any part of a period of Catastrophic Disability that -
- is applied to the Benefit Elimination Period at the onset of a Disability.
- continues beyond the end of the Maximum Benefit Period for Disability.

The Monthly Income Benefit is payable to You for Total Disability.

ReliaStar Life must receive proof that Your Disability is a Catastrophic Disability, as defined. You will no longer be eligible to receive this benefit on the date You are no longer Catastrophically Disabled.

The Assisted Living Benefit Amount is a percentage of Your Gross Disability Payment not to exceed the Maximum Monthly Income Benefit. This benefit is payable in addition to Your Monthly Income Benefit. The Assisted Living Benefit Percentage is shown in the Schedule of Benefits.

[If You are also insured under the Cost of Living Adjustment Rider, the cost of living adjustment [will] [will not] apply to Your Gross Disability Payment used in determining the Assisted Living Benefit Amount.]

The Assisted Living Benefit ends on the earlier of:
- The date You no longer satisfy the criteria for the Assisted Living Benefit.
- The date Your Monthly Income Benefits for Total Disability terminate, subject to the Extended Assisted Living Benefit provision.

Termination or amendment of Your coverage under the Group Policy or under this Assisted Living Benefit Rider will not prejudice a claim in effect at the time of such termination.

Extended Assisted Living Benefit
If, on the date that You reach Your Maximum Benefit Period under the Total Disability Benefit when benefits are no longer payable for the Disability, You are still Catastrophically Disabled, ReliaStar Life will pay You an Extended Assisted Living Lump Sum Benefit. The Extended Assisted Living Lump Sum Benefit is shown in the Schedule of Benefits. [If You are also insured under the Cost of Living Adjustment Rider, the cost of living adjustment [will] [will not] apply to the Extended Assisted Living Lump Sum Benefit shown in the Schedule of Benefits.]

Definitions

Activities of Daily Living -
- Bathing - the ability to wash oneself in a tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs normally worn.
- Toileting - the ability to get to and from the toilet, get on and off the toilet, perform associated personal hygiene and to care for clothing.
- Transferring - the ability to move into or out of a bed or chair with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices including mechanical or motorized devices.

- Continence - the ability to maintain control of bowel and bladder functions, or when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene including caring for a catheter or colostomy bag.
- Eating - the ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Catastrophically Disabled - due to Disability that begins while You are covered under this Benefit, You are:
- confined in a Hospital or similar institution and such confinement is expected to be permanent according to competent medical opinion;
- are unable to perform [2,3] or more Activities of Daily Living without hands on or standby assistance because of physical or mental impairment; or
- Cognitively Impaired.

Cognitively Impaired - a loss or deterioration in intellectual capacity that is:
- comparable to (and including) Alzheimer's disease and similar forms of irreversible dementia; and
- is measured by clinical evidence and standardized tests approved by ReliaStar Life that reliably measure impairment in short-term and long-term memory, orientation as to people, places or time, and deductive or abstract reasoning.

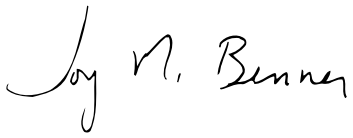
Cognitively Impaired does not include loss or deterioration as the result of a Mental Disorder.

Gross Disability Payment - the Monthly Income Benefit Amount [before ReliaStar Life subtracts Other Income Sources] [subject to the Relationship of Earnings to Insurance].

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

Executed by ReliaStar Life Insurance Company at its Home Office in Minneapolis, Minnesota.



Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

COST OF LIVING ADJUSTMENT RIDER

ReliaStar Life will adjust Your Monthly Income Benefit for increases in the cost of living if all of the following conditions are met when the cost of living adjustment is made.

- You have been Disabled for 12 consecutive months.
- You are receiving Monthly Income Benefits.
- Your current Monthly Earned Income is less than [75,80]% of Your [Indexed] Monthly Earned Income.

ReliaStar Life will make the cost of living adjustment [each year on January 1.] [on the anniversary of the first Monthly Income Benefit payment.]

ReliaStar Life applies the cost of living adjustment formula on a [compound] [simple] interest basis by:

- multiplying [the lesser of] [2-6%] [or 1/2 the percentage change in the CPI-W] times the Monthly Income Benefit received for Total Disability [net of prior cost of living adjustment] and
- adding the resulting number to Your Monthly Income Benefit being received for Total Disability.

You will not receive a cost of living adjustment after one of the following occurs:

- You cease being disabled.
- You have received [5-10] adjustments.
- The Group Policy terminates.

[For purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.]

[CPI-W - the Consumer Price Index for all Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures the periodic (usually monthly) basis for the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the CPI-W is discontinued or if its method of computation is changed, ReliaStar Life may use another national published index that it determines is comparable in scope and purpose to the CPI-W approved by the Insurance Commissioner of the state in which the Group Policy is delivered.]

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

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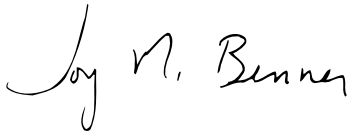

Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

GUARANTEED PURCHASE OPTION RIDER

Guaranteed Purchase Option - You may increase the amount of Your original Maximum Monthly Benefit, without medical evidence of insurability, by the percentage shown on the Schedule of Benefits on each Option Date. However, if You are Totally [or Residually] Disabled on the Option Date, any resulting increase in Your coverage will be deferred until You return to Active Work for at least 5 days and any increase will only apply to a new and separate Disability. Under no circumstances will a Purchase Option exercised during a period of Disability, or when benefits are being paid, provide a benefit for the current Disability or a current claim for benefits.

You will be given the opportunity to exercise this Purchase Option in writing at least 30 days before the Option Date, and You must exercise Your Purchase Option within the 30 day period prior to the Option Date.

However, You may not increase Your coverage beyond ReliaStar Life's maximum issue limits that are then in effect. ReliaStar Life has the right to require Your satisfactory evidence of financial insurability for the new Monthly Income Benefit.

If, at the time of claim, the Monthly Income Benefit for which You are filing a claim exceeds ReliaStar Life's maximum issue limits that were in effect at the time You increased Your Monthly Income Benefit, You will be eligible for the Monthly Income Benefit for which You were eligible based on ReliaStar Life's maximum issue limits. ReliaStar Life will refund any premium overpayments for a period not to exceed 2 years.

If You decline to increase Your original Monthly Income Benefit on any of the option dates, this Rider will terminate and You will have no additional rights to increase Your benefit. Your premium will be adjusted accordingly.

Option Date - The second, fourth, sixth, eighth and tenth anniversaries of Your first renewal Premium Due Date.

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

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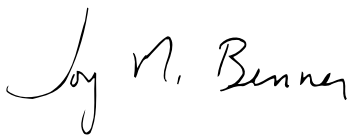

Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

HOSPITAL INCOME BENEFIT RIDER

Hospital Income Benefit - ReliaStar Life will pay the Daily Benefit Amount shown in the Schedule of Benefits for each day You are confined in a Hospital as an inpatient provided the confinement is due to Injury [or Sickness] and begins while You are insured under this Benefit.

Benefits will not exceed the Maximum Payment Period for this Benefit.

You will only be considered confined as an inpatient on a day for which a daily room and board charge is made for a full day.

The Daily Benefit and the Maximum Payment Period are shown in the Schedule of Benefits.

Successive Confinements - Successive periods of Hospital confinement due to the same or related causes and separated by less than [60-90] days will be considered the same period of Hospital confinement and counted against the Maximum Payment Period as though one period of Hospital confinement.

[Hospital Income Mental Disorder, Alcoholism or Chemical Dependency Limitation - The Hospital Income Benefits of the Group Policy for Mental Disorder, Alcoholism or Chemical Dependency will be limited to 10 days per period of confinement, subject to an aggregate lifetime maximum of 60 days.]

[Hospital Income Exclusion(s) - ReliaStar Life will not pay Benefit(s) for:
[• confinement in a Department of Veterans Affairs or other National Government owned or operated Hospital.]
[• confinement due to a normal pregnancy.]]

Termination - This Rider terminates on the earlier to occur of:
• age [65-70.]
• when coverage under the Group Policy and Your Certificate terminates.

This Rider is issued in consideration of the required additional premium. This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

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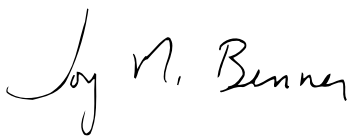

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ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

RECOVERY BENEFIT RIDER

ReliaStar Life will pay the lump sum Recovery Benefit if You return to active work in Your Regular Occupation on a full-time basis following a period of Total Disability for which benefits were payable under the Group Policy. The Recovery Benefit will be determined from the table below.

If the period of Total Disability was covered under the Group Policy and extended beyond the Benefit Elimination Period for at least:	**Amount of the Total Disability Benefit payable when You return to work following cessation of Total Disability:**
44 days or less	None
45 days but less than 2 months	An amount equal to 1/4 of the Monthly Income Benefit
2 months but less than 3 months	An amount equal to 1/2 of the Monthly Income Benefit
3 months but less than 4 months	An amount equal to 3/4 of the Monthly Income Benefit
4 months but less than 5 months	An amount equal to 1 times the Monthly Income Benefit
5 months but less than 6 months	An amount equal to 1 1/4 of the Monthly Income Benefit
6 months but less than 7 months	An amount equal to 1 1/2 of the Monthly Income Benefit
7 months but less than 8 months	An amount equal to 1 3/4 of the Monthly Income Benefit
8 months but less than 9 months	An amount equal to 2 times the Monthly Income Benefit
9 months but less than 10 months	An amount equal to 2 1/4 of the Monthly Income Benefit
10 months but less than 11 months	An amount equal to 2 1/2 of the Monthly Income Benefit
11 months but less than 12 months	An amount equal to 2 3/4 of the Monthly Income Benefit
12 months or longer	An amount equal to 3 times the Monthly Income Benefit

The Monthly Recovery Benefit will be based upon the Monthly Income Benefit that was payable, subject to all policy limitations and reductions, for the month that preceded Your return to work.

The combined period for which this Recovery Benefit is payable and other Disability Benefits of the Group Policy that are payable will not exceed the Maximum Benefit Period.

[ReliaStar Life will not consider a period of time for which benefits are payable under this Recovery Benefit as a period of Total Disability for the purpose of Waiver of Premium.]

If, after You return to work
- You have a recurrence of Your Total Disability and
- under the Recurrent Disability provision, the recurrence would extend the same period of Total Disability for which this Recovery Benefit was paid,

ReliaStar Life will reduce the Total Disability Benefits that then become payable by the amount ReliaStar Life paid under this Benefit.

However, if You return to work again, ReliaStar Life will restore the Recovery Benefit amount to You.

A Recovery Benefit is not payable if Residual Disability Benefits have been paid.

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This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

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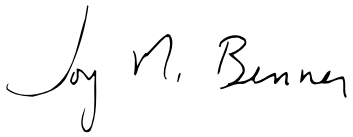

Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

BUSINESS OVERHEAD EXPENSE TOTAL DISABILITY BENEFIT RIDER

Business Overhead Expense Total Disability Benefit - ReliaStar Life will pay the lesser of:
- Your Monthly Business Overhead Expenses for each month based on the previous month's Monthly Business Overhead Expenses incurred; or
- The Maximum Monthly Business Overhead Benefit Amount subject to the provision entitled "Reduction in Coverage for Other Business Overhead Expense Insurance" below,

for each month that You incur Monthly Business Overhead Expenses while You are continuously Totally Disabled.

The period of Total Disability must:
- result from Disability.
- begin while You are covered under this Benefit of the Group Policy.
- continue beyond the end of the Benefit Elimination Period.
- require the Regular and Appropriate Care of a Doctor.

ReliaStar Life will not pay this Benefit for any part of a period of Total Disability that:
- is applied to the Benefit Elimination Period for this Benefit at the onset of Total Disability; or
- continues beyond the Benefit Period except as extended by the Benefit Continuation Upon Death provision.

This benefit is payable in addition to the Monthly Benefit payable under the Total Disability Benefit.

The Maximum Monthly Business Overhead Expense Benefit Amount, Benefit Elimination Period and Maximum Benefit Period for this Benefit are shown in the Schedule of Benefits.

Total Disability -see definition of Total Disability in the DEFINITIONS section of the Certificate.

Benefit Continuation Upon Death - If You die while the Business Overhead Expense Total Disability Benefit is payable, ReliaStar Life will continue to pay the benefit to Your estate until the earliest of the following:
- the third monthly payment is made to Your estate.
- the Maximum Benefit Period ends.
- the date Your business is sold.

Termination of Business Interest - Notify ReliaStar Life immediately if Your business interests end and You cease to incur Monthly Business Overhead Expenses. If notice cannot be sent immediately, send it as soon as reasonably possible, but in no event longer than one year from the date Your business interest ended. ReliaStar Life will refund, not to exceed one year's premium, the pro-rata share of unearned premium paid minus the sum of any claims paid during that period.

Reduction in Coverage for Other Business Overhead Expense Insurance

Reduction for Other Insurance - If You
- have other similar insurance that covers your Business Overhead Expenses with ReliaStar Life or with another insurance carrier, and
- You have not, before the date Your Disability commences, given ReliaStar Life notice on Your written application or on any other form provided by ReliaStar Life for giving such notice, that You have the other insurance,

ReliaStar Life will reduce Your Business Overhead Expense insurance benefits under the Group Policy.

The reduced amount will be the proportion that the amount ReliaStar Life would have paid bears to the total amount that You have, calculated as follows:

A = the monthly Business Overhead Expense Total Disability Benefit that would have been payable under the Group Policy.

B = the monthly Business Overhead Expense amount(s) that are payable under all other similar coverage for which You did not give ReliaStar Life notice.

C = A divided by (A plus B) multiplied by A.

"C" is the reduced Monthly Business Overhead Expense Total Disability Benefit amount.

ReliaStar Life will return a pro-rata refund of the premiums paid for the benefits that are in excess of the amount determined above. [The refund will be limited to the amount of premium overpaid for the preceding 12 month period.]

Definition

Monthly Business Overhead Expenses - Overhead expenses You incur in the operation of Your office each month. Such expenses include *only:*

- rent, electricity, heat, telephone, water and postage.
- employees' salaries and payments for group insurance and pension plans.
- monthly pro-rata portion of annual contributions and membership fees and dues.
- accounting and legal fees.
- mortgage interest and real estate tax payments on business premises owned and used by You in Your profession.
- mortgage interest and property tax payments on business equipment used in Your office.
- rental of business equipment (except automobiles or motor vehicles).
- depreciation on office furniture and/or equipment (excluding motor vehicles).
- other such expenses necessary to operate Your office.

If the office is jointly occupied, Monthly Business Overhead Expenses will mean Your portion of such expenses.

Business Overhead Expenses do not include:

- salary, fees, drawing account or any other remuneration for You and family members.
- salaries of employees of own profession.

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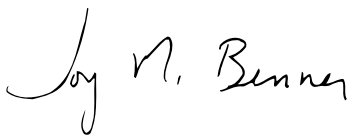

Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended by the addition of the following benefit:

SPOUSE[/DOMESTIC PARTNER] DISABILITY INCOME INSURANCE BENEFIT RIDER

Schedule of Benefits for Disability Income Insurance

Monthly Income Benefit Percentage ..... [40%-80%]

Maximum Monthly Income Benefit ..... $[1,000-25,000]

Maximum Benefit Period ..... [2 Years] [5 Years] [5 Years for Disability caused by Accident and 2 years for Disability caused by Sickness] [10 years] [to age 65] [to age 70]

Benefit Elimination Period ..... [30] [60] [90] [180] [365] Days

Definitions

[Domestic Partner -the Member and an adult [of the same sex] have completed and signed the Policyholder's Affidavit of Domestic Partnership and filed it with the Policyholder attesting that -
- neither are married to anyone and that they are the sole partners of each other.
- both are at least 18 years of age.
- they are not related by blood closer than would bar marriage in their state of residence.
- both are mentally competent to consent to contract.
- they have lived together continuously for at least [6] months.
- they live together in the same residence specified in the Affidavit and that it is their intention to reside together permanently.
- it is a committed and mutually exclusive relationship, with joint responsibility for each other's welfare and financial obligations.

The Policyholder must be notified in writing if there is any change of circumstances attested to in the Affidavit within 30 days of such change.]

Member - [an active Member of the Policyholder who is insured for Disability Income coverage under the Group Policy].

Spouse - the legal husband or wife of the Member.

You, Your - the Spouse [or Domestic Partner] of the Member.

Disability Income Insurance

Eligibility
You are eligible for coverage if:
- You are the Spouse [or Domestic Partner] of a Member insured for Disability Income Insurance under the Group Policy.
- You are at least age 18 and under age [60] on the date of application.
- You are Actively at Work on the date insurance is applied for.

Effective Date
Your insurance will become effective following ReliaStar Life's approval of your application and payment of the first premium. Your insurance will not become effective before the effective date of the Member's insurance.

Termination of Insurance
Your insurance under this Rider will terminate on the earlier of:
- The date You are no longer Actively at Work.
- The date You or the Member attain age [65-70].
- The date the Member's insurance terminates.
- The date You no longer meet the definition of Spouse [or Domestic Partner].
- The date You become a member of the armed forces of any country or international authority. In such event, the pro rata unearned premium will be returned to You for any period of full-time active duty for more than two months provided You notify ReliaStar Life within 12 months of entering the armed forces.
- The premium due date when the required premium is not paid except as provided in the Individual Grace Period provision in this Certificate.
- The date ReliaStar Life receives written notice to terminate Your insurance or the date stated in the notice if later.
- The date the Group Policy is terminated.

Termination of Your insurance will be without prejudice to any claims that originated prior to the date of termination.

Proof of Insurability
You must make written application and submit any proof of insurability that may be required by ReliaStar Life.

Qualifying for Benefits
ReliaStar Life pays the Monthly Income Benefit for Total Disability as described in the Certificate if You become Disabled and qualify to receive benefits. To qualify for benefits, all of the following conditions must be met:
You must -
- be insured on the date You become Disabled and the condition causing Your Disability is not excluded from coverage.
- be insured on the date the Benefit Elimination Period begins.
- send written notice of the Disability as described in the Claim Procedures section of the Certificate.
- provide required proof of Disability due to [Sickness or] Injury.

The benefit payable, as well as the benefit limitations, will be based on this Rider's Schedule of Benefits in effect on the date You become Disabled.

No Additional Disability Income Benefits are available under this Rider.

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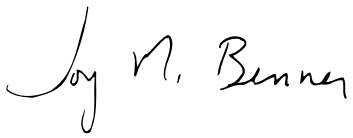

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Minneapolis, Minnesota 55440

TRANSITION RIDER

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended as follows:

In order to prevent loss of insurance because of a transfer of insurance carriers, if You were covered by the Prior Policy, the following provisions will apply to You.

Pre-existing Conditions: If You were insured by and eligible to receive benefits under the Prior Policy on the day immediately before the Effective Date of the Group Policy, the Pre-existing Conditions Limitation will end on the earliest of:
- the Effective Date of Your Coverage under this plan, if Your coverage for the Disability was not limited by a Pre-existing Condition restriction under the Prior Policy, or
- the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a Pre-existing Condition Limitation/Exclusion under the Prior Policy.

The amount of the Monthly Income Benefit payable for the Pre-existing Condition will be the lesser of:
- the Monthly Income Benefit which was paid by the Prior Policy, or
- the Monthly Income Benefit provided by the Group Policy.

The Pre-existing Conditions Limitation will apply after the Effective Date of Your coverage under this plan to the amount of a benefit increase which results from a change from the Prior Policy to the Group Policy, a change in benefit options, a change of class or a change in the Group Policy.

Previously Totally Disabled, but Returned to Work on Policy Effective Date: If you:
- received Monthly Income Benefits for Total Disability under the Prior Policy;
- returned to work before the Group Policy Effective Date; and
- within [6] months of Your return to work:
  - You have a recurrence of the same Disability while covered under the Group Policy; and
  - there are no benefits available for the recurrence under the Prior Policy;

the Benefit Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further Benefit Elimination Period under the Prior Policy. If, however, the recurrence is covered by the Prior Policy, no benefits will be provided for it under the Group Policy.

[Guaranteed Purchase Option: If you were covered by the Guaranteed Purchase Option of the Prior Policy, then for the purpose of determining Your Guaranteed Purchase Option dates and when these would expire, the dates will be the same as would have applied under the Prior Policy had it remained in force.]

Benefit Amounts and Periods: Your Monthly Income Benefit, Maximum Benefit Period and Benefit Elimination Period will be those available under the Group Policy which, on the Policy Effective Date, would most closely approximate those afforded under the Prior Policy.

Specified Condition Exclusion: ReliaStar Life will not cover You for any loss of Disability under the Group Policy resulting from your Total Disability which the Prior Policy excluded by name or specific description. Any evidence of insurability required will not apply to You if You are covered under the Prior Policy on the day prior to the Effective Date of the Group Policy.

Incontestability: The period of time You were covered under the Prior Policy will be applied toward satisfaction of the Incontestability provision of the Group Policy.

Non-Duplication of Benefits between the Group Policy and the Prior Policy: In no event will any Disability or loss be covered under the Group Policy if it is paid or payable under the Prior Policy or paid or payable under a settlement by the prior carrier related to coverage under the Prior Policy.

DEFINITIONS

For purposes of this Rider, the following definitions apply:

Prior Policy - the group Disability Income policy under which You were covered on the date immediately prior to the effective date of the Group Policy.

Group Policy - this group Total Disability Policy issued by ReliaStar Life Insurance Company.

This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

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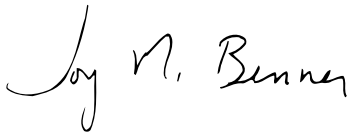

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ReliaStar Life Insurance Company
Minneapolis, Minnesota 55440

SPECIFIED CONDITION EXCLUSION RIDER

Subject to the terms and conditions of the Group Policy and Certificate to which this Rider is attached, the Group Policy and Certificate are amended as follows:

The Group Policy will not cover You for any Disability caused by the specified excluded condition(s):

[Name of Insured Person: John Doe]

Specified Excluded Condition: [Any disorder or ailment of the heart or circulatory system]

Accepted by:

_____

Signature of Insured Person

_____

Date

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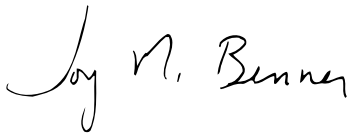

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Minneapolis, Minnesota 55440

POLICY [AND CERTIFICATE] MODIFICATIONS RIDER

Subject to the terms and conditions of the Group Policy [and Certificate] to which this Rider is attached, the Group Policy [and Certificate] [is are] amended as follows:

[Text]

This Rider forms a part of Policy Number [GH-12345-6] issued to [ABC Association] [and to the Certificate] to which it is attached.

This Rider is effective on the later to occur of the effective date of the Group Policy or Certificate to which it is attached.

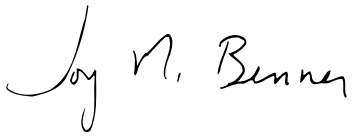
This Rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Group Policy except as stated herein.

Accepted by:

_____
Signature of Insured Person

_____
Date

Executed by ReliaStar Life Insurance Company at its Home Office in Minneapolis, Minnesota.



Secretary

Policyholder Logo to be inserted here

Application for Group Disability Income Insurance

Please complete the entire application. Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

Association membership # _____

Your Name (*last, first, middle*)		☐ Male ☐ Female
Date of Birth	Social Security Number	Annual Earned Income $_____
Address	City	State Zip
Home Phone	Work Phone	Email

Current Occupation and Primary Duties: _____

Are you now performing, and have you over the last 90 days, performed the full-time duties of your occupation/profession for a minimum of 30 hours per week? ☐ Yes ☐ No If no, explain: _____

Do you have any other disability income (or BOE) in force or pending with any other company? If yes, provide company, amount, and if you plan on replacing with this insurance. _____

Have you smoked (cigarettes, cigars, pipe etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

2. Choose your coverage amount

Applying for: ☐ Disability Income Insurance ☐ Business Overhead Expense (also complete BOE Supplement)

Member's Monthly Coverage Amount: $_____ *(in increments of $100)*

Choose a monthly coverage amount from $500 up to the maximum monthly coverage amount you are eligible for. Remember, your monthly coverage amount, plus any other disability income coverage you may have, cannot exceed 60% of your gross earned monthly income.

Indicate business entity type: ☐ Sole proprietorship ☐ LLC ☐ S-Corporation ☐ C-Corporation ☐ LLP ☐ Partnership

Benefit Elimination Period in days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Maximum Benefit Period in years: ☐ 2 ☐ 5 ☐ To Age 65 ☐ To Age 70

Optional Benefit Rider(s): ☐ Accidental Death & Dismemberment Benefit Rider

3. Medical History

1. Provide your height and weight: Height: _____ft _____" Weight: _____ lbs
2. To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system, or tested positive for the antibodies to the HIV Virus? ☐ Yes ☐ No
3. Have you been advised to have any medical treatment that has not been done, or is any surgical procedure contemplated? ☐ Yes ☐ No
4. In the past 10 years, have you ever sought help or received advice or treatment for the use of alcohol or drugs? ☐ Yes ☐ No
5. In the past 5 years, have you ever been in a hospital or other institution for surgery, observation, diagnosis or treatment? ☐ Yes ☐ No
6. Within the past 10 years, to the best of your knowledge and belief, have you been diagnosed or treated by a health care practitioner for:
   a. High blood pressure, stroke, heart attack, or other heart or circulatory disorder? ☐ Yes ☐ No
   b. Diabetes? Cancer or tumor, including leukemia, or Hodgkin's disease? ☐ Yes ☐ No
   c. Arthritis, other disease or disorder of the bones or joints, including the neck or spine, or chronic pain/fatigue or Fibromyalgia? ☐ Yes ☐ No
   d. Seizure disorder, paralysis, neuromuscular disorder, neurological disorder, mental, nervous or eating disorder, anxiety or depression? ☐ Yes ☐ No
   e. Asthma, emphysema, chronic obstructive pulmonary disease or other lung disorder? ☐ Yes ☐ No
   f. Kidney, stomach, liver (including hepatitis), pancreas, intestinal, prostate or gynecological disorder? ☐ Yes ☐ No
7. Are you now pregnant? If so, what is the due date _____ ☐ Yes ☐ No
8. Have you ever been declined for Life or Disability Insurance or offered a rated or restricted policy? ☐ Yes ☐ No

9. List the name, address, and phone number of your regular physician/health practitioner and give the date and reason last consulted:

_____

_____

If you answer "yes" to any of the questions above, please give full details below. Attach additional sheets if needed.

Q #	Conditions/Illness/Diagnosis	Treatment/Results (If for High Blood Pressure, please provide most recent reading)	Date of Onset	Date Last Seen	Physician/Health Practitioner's Name, complete mailing address, & phone No.

[4.] Select your premium payment option *(Choose only one)*

☐ **Option 1: ELECTRONIC FUNDS TRANSFER (EFT):** ☐ Monthly ☐ Quarterly

I request and authorize _____ Plan Administrator to make withdrawals against the account specified on the attached ☐ voided check ☐ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X _____ Date: _____

Signature(s) as required on checks issued against this account

☐ **Option 2: CREDIT CARD:** ☐ Monthly ☐ Quarterly

Credit Card Number:	
Expiration Date:	
Name on Credit Card (exactly as printed):	
Card Identification Code (CID)*	

*Visa and MasterCard Credit Card Users: Flip your card over and look at the signature box. You should see a 16-digit credit card number followed by a special 3-digit code. This 3-digit code is your Card Identification Code.

I request and authorize _____ Plan Administrator to initiate debit entries and to initiate, if necessary, credit entries and adjustment (for any debit entries in error) to my account, hereinafter called Financial Institution, to credit and/or debit the same to such account.

This authority is to remain in full force and effect until Plan Administrator has received written notification from me of its termination in such time and in such manner as to afford Plan Administrator and Financial Institution a reasonable opportunity to act on it.

X _____ Date: _____

Signature(s)

☐ **Option 3: DIRECT BILL** (Billing dates will begin after coverage is approved and initial premium has been received.)

☐ Annually ☐ Semi-Annually ☐ Quarterly

5. Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.
For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life or its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____
Member Signature

Policyholder Logo to be inserted here

Simplified Issue Application for Group Disability Income Insurance

Please use this form to apply for **Simplified Issue** coverage during the specified enrollment period. Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

Association membership # _____

Your Name (*last, first, middle)*			☐ Male ☐ Female
Date of Birth	Social Security Number		Annual Earned Income $_____
Address	City	State	Zip
Home Phone	Work Phone	Email	
Who is/are your employer(s)		Occupation	
Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No			
Have you smoked (cigarettes, cigars, pipe etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No			

2. Choose your coverage amount

Choose a monthly coverage amount in increments of $100 up to the maximum monthly coverage amount you are eligible for (see chart below). Remember, your monthly coverage amount, plus any other disability income coverage you may have, cannot exceed 60% of your gross earned monthly income.

Maximum Monthly Coverage Amount		
Under age 35	**Ages 35-39**	**Ages 40-49**
$2,000	$1,500	$1,000

Benefit Elimination Period: 90 days
Maximum Benefit Period: 2 years accident / 2 years sickness
Optional Benefit Rider(s):
☐ Business Overhead Expense Benefit Rider

Member's Monthly Coverage Amount: $_____
in increments of $100

3. Certify this Health Statement

By signing this form, I hereby certify that during the last 5 years I have not been treated or diagnosed by a member of the medical profession for a heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure), drug or alcohol abuse, anxiety or depression, cancer or tumor, arthritis, joint, back, chronic pain or fatigue, muscle or connective tissue disorder, AIDS, ARC or an immune system disorder.

I also agree, considering my height, I do not weigh more than the following:

Up to 5'	190 lbs.
5' to 5'6"	220 lbs.
5'7" to 6'	260 lbs.
Over 6'	300 lbs.

I have not been previously declined disability insurance coverage with this or any other company.

If you want to apply for a higher coverage amount, or cannot certify this statement, please contact the Plan Administrator for a fully underwritten application.

4. Select your premium payment option *(Choose only one)*

☐ **Option 1: ELECTRONIC FUNDS TRANSFER (EFT):** ☐ Monthly ☐ Quarterly
I request and authorize _____ Plan Administrator to make withdrawals against the account specified on the attached ☐ voided check ☐ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X _____ Date: _____
Signature(s) as required on checks issued against this account

☐ **Option 2: CREDIT CARD:** ☐ Monthly ☐ Quarterly

Credit Card Number:	
Expiration Date:	
Name on Credit Card (exactly as printed):	
Card Identification Code (CID)*	

*Visa and MasterCard Credit Card Users: Flip your card over and look at the signature box. You should see a 16-digit credit card number followed by a special 3-digit code. This 3-digit code is your Card Identification Code.

I request and authorize _____ Plan Administrator to initiate debit entries and to initiate, if necessary, credit entries and adjustment (for any debit entries in error) to my account, hereinafter called Financial Institution, to credit and/or debit the same to such account.

This authority is to remain in full force and effect until Plan Administrator has received written notification from me of its termination in such time and in such manner as to afford Plan Administrator and Financial Institution a reasonable opportunity to act on it.

X _____ Date: _____
Signature(s)

☐ **Option 3: DIRECT BILL** (Billing dates will begin after coverage is approved and initial premium has been received.)
☐ Annually ☐ Semi-Annually ☐ Quarterly

5. Read this information carefully, then sign and date below

I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the information I have provided is complete and accurate.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____
Member Signature

Policyholder Logo to be inserted here

Application for Business Overhead Expense Insurance

Applicant must have Group Disability Income Insurance in force with ReliaStar Life Insurance Company in order to apply for this coverage. Please complete the entire application. Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

Association membership # _____

Your Name (*last, first, middle*)		☐ Male ☐ Female
Date of Birth	Social Security Number	Annual Earned Income $_____
Address	City State Zip	
Home Phone	Work Phone	Email

Current Occupation and Primary Duties: _____

Are you now performing, and have you over the last 90 days, performed the full-time duties of your occupation/profession for a minimum of 30 hours per week? ☐ Yes ☐ No If no, explain: _____

Do you have any BOE in force or pending with any other company? If yes, provide company, amount, and if you plan on replacing with this insurance. _____

Have you smoked (cigarettes, cigars, pipe etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

2. Choose your coverage amount

BOE benefit amount requested: $_____ *(per month)*

Indicate business entity type: ☐ Sole proprietorship ☐ LLC ☐ S-Corporation ☐ C-Corporation ☐ LLP ☐ Partnership

Benefit Elimination Period in days: ☐ 30 ☐ 60 **Maximum Benefit Period in years:** ☐ 1 ☐ 2

3. Overhead Expenses

1. Annual expenses as reported on your federal tax return. Please use the actual figures that appear on your business tax return:

Annual Eligible Expenses	Expenses for last year
Rent or mortgage interest payments	
Electricity	
Heat	
Telephone	
Water	
Postage	
Salaries of employees (Do not include salaries of family members, or other members of own profession)	
Medical insurance for above employees	
Interest on business loans (excluding revolving credit or lines of credit, or other financial tools for cash flow management)	
Property taxes	
Accounting and legal fees	
Maintenance, office supplies, repairs, leasing costs or loan costs for existing furniture and/or equipment (excluding motor vehicles)	
Depreciation on office furniture and/or equipment (excluding motor vehicles)	
Other: _____	

2. Total eligible annual expenses: _____
3. Total eligible monthly expenses: _____

[4.] Medical History

1. Provide your height and weight: Height: _____ft _____" Weight: _____ lbs
2. To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system, or tested positive for the antibodies to the HIV Virus? ☐ Yes ☐ No
3. Have you been advised to have any medical treatment that has not been done, or is any surgical procedure contemplated? ☐ Yes ☐ No
4. In the past [10] years, have you ever sought help or received advice or treatment for the use of alcohol or drugs? ☐ Yes ☐ No
5. In the past 5 years, have you ever been in a hospital or other institution for surgery, observation, diagnosis or treatment? ☐ Yes ☐ No
6. Within the past [10] years, to the best of your knowledge and belief, have you been diagnosed or treated by a health care practitioner for:
   a. High blood pressure, stroke, heart attack, or other heart or circulatory disorder? ☐ Yes ☐ No
   b. Diabetes? Cancer or tumor, including leukemia, or Hodgkin's disease? ☐ Yes ☐ No
   c. Arthritis, other disease or disorder of the bones or joints, including the neck or spine, or chronic pain/fatigue or Fibromyalgia? ☐ Yes ☐ No
   d. Seizure disorder, paralysis, neuromuscular disorder, neurological disorder, mental, nervous or eating disorder, anxiety or depression? ☐ Yes ☐ No
   e. Asthma, emphysema, chronic obstructive pulmonary disease or other lung disorder? ☐ Yes ☐ No
   f. Kidney, stomach, liver (including hepatitis), pancreas, intestinal, prostate or gynecological disorder? ☐ Yes ☐ No
7. Are you now pregnant? If so, what is the due date _____ ☐ Yes ☐ No
8. Have you ever been declined for Life or Disability Insurance or offered a rated or restricted policy? ☐ Yes ☐ No
9. List the name, address, and phone number of your regular physician/health practitioner and give the date and reason last consulted:

_____

_____

If you answer "yes" to any of the questions above, please give full details below. Attach additional sheets if needed.

Q #	Conditions/Illness/Diagnosis	Treatment/Results (If for High Blood Pressure, please provide most recent reading)	Date of Onset	Date Last Seen	Physician/Health Practitioner's Name, complete mailing address, & phone No.

5. Select your premium payment option *(Choose only one)*

☐ **Option 1: ELECTRONIC FUNDS TRANSFER (EFT):** ☐ Monthly ☐ Quarterly

I request and authorize _____ Plan Administrator to make withdrawals against the account specified on the attached ☐ voided check ☐ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X _____ Date: _____

Signature(s) as required on checks issued against this account

☐ **Option 2: CREDIT CARD:** ☐ Monthly ☐ Quarterly

Credit Card Number:	
Expiration Date:	
Name on Credit Card (exactly as printed):	
Card Identification Code (CID)*	

*Visa and MasterCard Credit Card Users: Flip your card over and look at the signature box. You should see a 16-digit credit card number followed by a special 3-digit code. This 3-digit code is your Card Identification Code.

I request and authorize _____ Plan Administrator to initiate debit entries and to initiate, if necessary, credit entries and adjustment (for any debit entries in error) to my account, hereinafter called Financial Institution, to credit and/or debit the same to such account.

This authority is to remain in full force and effect until Plan Administrator has received written notification from me of its termination in such time and in such manner as to afford Plan Administrator and Financial Institution a reasonable opportunity to act on it.

X _____ Date: _____

Signature(s)

☐ **Option 3: DIRECT BILL** (Billing dates will begin after coverage is approved and initial premium has been received.)

☐ Annually ☐ Semi-Annually ☐ Quarterly

6. Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.
For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life or its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____
Member Signature

Policyholder Logo to be inserted here

Business Overhead Expense Supplement to Application for Group Disability Income Insurance

Please complete the entire application. **The applicant must also complete the Application for Group Disability Income Insurance in order to apply for this coverage.** Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Your Name: _____ Social Security #____-____-_____

(last, first, middle)

2. Choose your coverage amount

BOE Supplement benefit amount requested: $_____ *(per month)*

Indicate business entity type: ☐ Sole proprietorship ☐ LLC ☐ S-Corporation ☐ C-Corporation ☐ LLP ☐ Partnership

Benefit Elimination Period in days: ☐ 30 ☐ 60 **Maximum Benefit Period in years:** ☐ 1 ☐ 2

3. Overhead Expenses

1. Annual expenses as reported on your federal tax return. Please use the actual figures that appear on your business tax return:

Annual Eligible Expenses	Expenses for last year
Rent or mortgage interest payments	
Electricity	
Heat	
Telephone	
Water	
Postage	
Salaries of employees (Do not include salaries of family members, or other members of own profession)	
Medical insurance for above employees	
Interest on business loans (excluding revolving credit or lines of credit, or other financial tools for cash flow management)	
Property taxes	
Accounting and legal fees	
Maintenance, office supplies, repairs, leasing costs or loan costs for existing furniture and/or equipment (excluding motor vehicles)	
Depreciation on office furniture and/or equipment (excluding motor vehicles)	
Other: _____	

2. Total eligible annual expenses: _____
3. Total eligible monthly expenses: _____

4. Read this information carefully, then sign and date below

I understand that this form is a supplement to the Group Disability Application for ReliaStar Life and that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the information I have provided is complete and accurate.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____

Member Signature

Policyholder Logo to be inserted here

Application for Group Disability Income Insurance

Member must have current coverage through this policy in order for Dependent Spouse or Domestic Partner of Member to be eligible to apply. Please complete the entire application. Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

You are applying as: ☐ Dependent Spouse of Member ☐ Domestic Partner of Member

Your Name (*last, first, middle)*			☐ Male ☐ Female
Name of Member insured under this policy		Association membership #	
Date of Birth	Social Security Number	Annual Earned Income $_____	
Address	City	State	Zip
Home Phone	Work Phone	Email	

Current Occupation and Primary Duties: _____

Are you now performing, and have you over the last 90 days, performed the full-time duties of your occupation/profession for a minimum of 30 hours per week? ☐ Yes ☐ No If no, explain: _____

Do you have any other disability income in force or pending with any other company? If yes, provide company, amount, and if you plan on replacing with this insurance. _____

Have you smoked (cigarettes, cigars, pipe etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

2. Choose your coverage amount

Applying for: ☐ Disability Income Insurance **Monthly Coverage Amount:** $_____ *(in increments of $100)*

Choose a monthly coverage amount from $500 up to the maximum monthly coverage amount you are eligible for. Remember, your monthly coverage amount, plus any other disability income coverage you may have, cannot exceed 60% of your gross earned monthly income.

Benefit Elimination Period in days: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Maximum Benefit Period in years: ☐ 2 ☐ 5 ☐ To Age 65 ☐ To Age 70

3. Medical History

1. Provide your height and weight: Height: _____ft _____" Weight: _____ lbs
2. To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system, or tested positive for the antibodies to the HIV Virus? ☐ Yes ☐ No
3. Have you been advised to have any medical treatment that has not been done, or is any surgical procedure contemplated? ☐ Yes ☐ No
4. In the past 10 years, have you ever sought help or received advice or treatment for the use of alcohol or drugs? ☐ Yes ☐ No
5. In the past 5 years, have you ever been in a hospital or other institution for surgery, observation, diagnosis or treatment? ☐ Yes ☐ No
6. Within the past 10 years, to the best of your knowledge and belief, have you been diagnosed or treated by a health care practitioner for:
   a. High blood pressure, stroke, heart attack, or other heart or circulatory disorder? ☐ Yes ☐ No
   b. Diabetes? Cancer or tumor, including leukemia, or Hodgkin's disease? ☐ Yes ☐ No
   c. Arthritis, other disease or disorder of the bones or joints, including the neck or spine, or chronic pain/fatigue or Fibromyalgia? ☐ Yes ☐ No
   d. Seizure disorder, paralysis, neuromuscular disorder, neurological disorder, mental, nervous or eating disorder, anxiety or depression? ☐ Yes ☐ No
   e. Asthma, emphysema, chronic obstructive pulmonary disease or other lung disorder? ☐ Yes ☐ No
   f. Kidney, stomach, liver (including hepatitis), pancreas, intestinal, prostate or gynecological disorder? ☐ Yes ☐ No

7. Are you now pregnant? If so, what is the due date _____ ☐ Yes ☐ No
8. Have you ever been declined for Life or Disability Insurance or offered a rated or restricted policy? ☐ Yes ☐ No
9. List the name, address, and phone number of your regular physician/health practitioner and give the date and reason last consulted:

_____

_____

If you answer "yes" to any of the questions above, please give full details below. Attach additional sheets if needed.

Q #	Conditions/Illness/Diagnosis	Treatment/Results (If for High Blood Pressure, please provide most recent reading)	Date of Onset	Date Last Seen	Physician/Health Practitioner's Name, complete mailing address, & phone No.

4. Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime. If coverage is approved, the premiums will be added to the same premium payment method in place for the member.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.
For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life or its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____
Your Signature

X_____ **Date:** _____
Member Signature

Policyholder Logo to be inserted here

Simplified Issue Application for Group Disability Income Insurance

Member must have current coverage through this policy in order for Dependent Spouse or Domestic Partner of Member to be eligible to apply. Please use this form to apply for **Simplified Issue** coverage during the specified enrollment period. Please print clearly in dark ink and mail to ***[Name and address of administrator, city, state, zip, Phone, fax].***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

You are applying as: ☐ Dependent Spouse of Member ☐ Domestic Partner of Member

Your Name *(last, first, middle)*			☐ Male ☐ Female
Name of Member insured under this policy		Association membership #	
Date of Birth	Social Security Number	Annual Earned Income $_____	
Address	City	State	Zip
Home Phone	Work Phone	Email	
Who is/are your employer(s)		Occupation	

Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No

Have you smoked (cigarettes, cigars, pipe etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

2. Choose your coverage amount

Choose a monthly coverage amount in increments of $100 up to the maximum monthly coverage amount you are eligible for (see chart below). Remember, your monthly coverage amount, plus any other disability income coverage you may have, cannot exceed 60% of your gross earned monthly income.

Maximum Monthly Coverage Amount		
Under age 35	**Ages 35-39**	**Ages 40-49**
$2,000	$1,500	$1,000

Monthly Coverage Amount: $_____ *in increments of $100*

Benefit Elimination Period: 90 days

Maximum Benefit Period: 2 years accident / 2 years sickness

3. Certify this Health Statement

By signing this form, I hereby certify that during the last 5 years I have not been treated or diagnosed by a member of the medical profession for a heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure), drug or alcohol abuse, anxiety or depression, cancer or tumor, arthritis, joint, back, chronic pain or fatigue, muscle or connective tissue disorder, AIDS, ARC or an immune system disorder.

I also agree, considering my height, I do not weigh more than the following:

Up to 5'	190 lbs.
5' to 5'6"	220 lbs.
5'7" to 6'	260 lbs.
Over 6'	300 lbs.

I have not been previously declined disability insurance coverage with this or any other company.

If you want to apply for a higher coverage amount, or cannot certify this statement, please contact the Plan Administrator for a fully underwritten application.

4. Read this information carefully, then sign and date below

I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. If coverage is approved, the premiums will be added to the same premium payment method in place for the member. By signing this application, I acknowledge that the information I have provided is complete and accurate.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____
Your Signature

X_____ **Date:** _____
Member Signature

Policyholder Logo to be inserted here

Application for Accident Only Group Disability Income Insurance

Please use this form to apply for **Accident Only Group Disability Income Insurance**. Please print clearly in dark ink and mail to ***Name and address of administrator, city, state, zip, Phone, fax.***

Name of Policyholder here **#####-# (policy number)**

1. Tell us about yourself

Your Name (*last, first, middle)*		☐ Male ☐ Female
Date of Birth	Social Security Number	Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No
Address	City	State Zip
Home Phone	Work Phone	Email
Who is/are your employer(s)		Occupation

2. Choose your coverage amount

Choose a monthly coverage amount: ☐$5,000 ☐$2,500 **Benefit Elimination Period:** 90 days **Maximum Benefit Period:** 2 yrs

3. Select your premium payment option *(Choose only one)*

☐ **Option 1: ELECTRONIC FUNDS TRANSFER (EFT):** ☐ Monthly ☐ Quarterly

I request and authorize _____ Plan Administrator to make withdrawals against the account specified on the attached ☐ voided check ☐ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X _____ Date: _____

Signature(s) as required on checks issued against this account

☐ **Option 2: CREDIT CARD:** ☐ Monthly ☐ Quarterly

Credit Card Number:		Expiration Date:	
Name on Credit Card (exactly as printed):		Card Identification Code (CID)*	

*Visa and MasterCard Credit Card Users: Flip your card over and look at the signature box. You should see a 16-digit credit card number followed by a special 3-digit code. This 3-digit code is your Card Identification Code.

I request and authorize _____ Plan Administrator to initiate debit entries and to initiate, if necessary, credit entries and adjustment (for any debit entries in error) to my account, hereinafter called Financial Institution, to credit and/or debit the same to such account.

This authority is to remain in full force and effect until Plan Administrator has received written notification from me of its termination in such time and in such manner as to afford Plan Administrator and Financial Institution a reasonable opportunity to act on it.

X _____ Date: _____

Signature(s)

☐ **Option 3: DIRECT BILL** (Billing dates will begin after coverage is approved and initial premium has been received.)

☐ Annually ☐ Semi-Annually ☐ Quarterly

4. Read this information carefully, then sign and date below

I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the information I have provided is complete and accurate.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X_____ **Date:** _____

Member Signature